Mt. Rose
Foot & Ankle Specialists

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DATE: ___/___/_____

Patient Information

Legal First Name: _____ Legal MI: _____ Legal Last Name: _____

Preferred name: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Date of Birth: _____/_____/_____ Social Security Number: _____

Email: _____

Employer: _____ Occupation: _____

Emergency Contact Name/Relationship: _____ Phone Number: _____

Primary Care Doctor: _____ Last Date Seen (MM-DD-YEAR): _____-_____-_____

Primary care doctor Phone Number: _____

Preferred Pharmacy Name: _____ Preferred Pharmacy Address: _____

How did you hear about us? __ Doctor __Family/Friend __Insurance __ Other: _____

IS PATIENT A MINOR? YES NO
PARENT/LEGAL GUARDIAN'S NAME AND PHONE NUMBER_____
PARENT/LEGAL GUARDIAN'S RELATIONSHIP TO PATIENT_____
PARENT/LEGAL GUARDIAN'S NAME AND PHONE NUMBER_____
PARENT/LEGAL GUARDIAN'S RELATIONSHIP TO PATIENT_____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Co-Payment Amount: $_____ Co-payment Amount: _____

Deductible Amount: $_____ Deductible Amount: $_____

Member ID Number: _____ Member ID Number: _____

Subscriber's Name: _____ Subscribers Name: _____

Subscriber's DOB: _____-_____-_____ Subscriber's DOB: _____-_____-_____

Subscriber's SSN: _____-_____-_____ Subscriber's SSN: _____-_____-_____

Financial responsible party if different from subscriber

Name: _____ DOB:_____ Phone Number: _____

Address: _____

BILLING AND COLLECTION POLICIES

Our goal is to provide you with high quality and efficient care. There are many details involved in the process of payment for the services that you receive. In order for this process to flow smoothly, it is essential that you understand what information we must share with each other and with health insurance companies, and what both our responsibilities are.

Upon scheduling and registration, we require you to provide your medical insurance card (if you have coverage), photo identification, your address, date of birth, and phone number as well. Our billing process works better if you provide social security numbers as well.

Health Insurance Cards: Upon scheduling each appointment, our team will ask you to verify your insurance information and will ask to see your insurance card upon check in at each appointment. Please bring your card to every appointment and notify the office at your first appointment if any changes have occurred. Intentionally failing to notify us of changes to your insurance coverage may constitute fraud, and we may be obligated to report such behavior to the authorities. We will not engage in any fraudulent practices under any circumstances.

Keeping appointments: should you not arrive for a scheduled appointment, unless that appointment has been cancelled at least 1 full business day in advance, you may be charged $40 for each non-show occurrence. Should this occur more than twice within a 12-month period, you may be dismissed from the practice. By signing below, you accept this policy.

Health Insurance Plans: it is your responsibility to understand the provisions of your health insurance plan and coverage. As helpful as we pride ourselves in being, our team cannot expect to know the details of your particular plan, as we see hundreds of different plans every week. We recommend contacting your carrier prior to receiving services in order to verify your coverage levels and responsibilities.

Authorizations: You are responsible to obtain all necessary referrals, or other require documentation prior to your appointment. If our team office determines that your plan requires a referral, and you do not provide such referral, you may be required to sign a waiver in order to receive services. Additionally, even should our team fail to request such a waiver, you will nonetheless be responsible for all changes that are not paid by your insurance carrier due to lack of authorization. By signing below, you accept these policies.

Copayments: it is our responsibility, as detailed by the terms of our contract with health insurance companies, to collect all copayments at the time of your appointment. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any copayment amounts at the time of your appointment. Please have your payment ready upon check in, by signing below, you accept these policies.

Telemedicine and/or telephonic visits: Evaluation and follow-up by your provider may be done via telemedicine and/or telephonic systems. By signing below, you consent for this evaluation and acknowledge responsibility, as detailed by the terms of your health insurance coverage, to pay any copays, coinsurance, or deductibles for this care.

Previous balances and/or deductibles: It is our responsibility, as detailed by the terms of our contracts with health insurance companies we participate with, to bill you for any portion of your treatment that your health carrier assigns to your responsibility. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay such portion. If you do not remit full payment on any such bills within a reasonable period and with reasonable notice, your account will be sent to collections (and subject to an additional collection fee) and/or legal action will be pursued. You may be dismissed as a patient by our practice for failure to meet your financial obligations, by signing below, you accept these policies.

Health insurance non-payment: services that have not been paid by your health insurance carrier within 60 days of claim submission will become your responsibility to pay in full. Should your health insurance carrier later pay us for those services you paid for, you will be reimbursed. By signing below, you accept this policy.

Self-pay patients: If you do not have health insurance, have coverage through a carrier with which we do not participate, or are receiving a non-covered service, it is our policy that you must pay for your service in full before leaving the office. By signing below, you accept these policies.

I have read, fully understand, accept, and agree to comply with all the above policies. I consent to the assignment of authorized health insurance benefits by my health insurer to Mt Rose Foot and Ankle Specialists for any services furnished to me or my dependents.

Signature of patient: _____

Date: _____

If patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and indicate relationship to the patient.

ASSIGNMENT OF BENEFITS/AUTHORIZATIONS

I hereby authorize payment of my health insurance benefits directly to Mt Rose Foot and Ankle Specialists. I also authorize them and their representatives to submit claims for medical insurance benefits, inquire about eligibility and benefits, appeal and dispute claims decisions and request hearings, and to represent me in these actions. I authorize them to release medical and identifying information for the above purposes. I agree to pay all deductibles and co-pays at the time of service. I understand that payment for all services is ultimately my responsibility.

I understand the office policy stating there is a **$25.00** charge for any medical forms required to be filled out by the physician. This is including but not limited to Family Medical Leave of Absence (FMLA) (which will not be filled out until day of or after procedure), Disability, and Physician Assessment Forms. Please allow 5-7 business days for completion of all paperwork.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement if you wish.

- ☐ I would like to receive a copy of the office's Notice of Privacy Practices.
- ☐ I would not like to receive a copy of the office's Notice of Privacy Practices.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____ _____ _____
Please print your name here *Signature* *Date*

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below name(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

- ☐ Office may only speak with patient.

_____ _____
_____ _____
_____ _____

- ☐ Office may leave a detailed message to the number I have provided _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but could not be obtained because:

- ☐ The patient refused to sign
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgement
- ☐ We couldn't communicate with the patient
- ☐ Other (please provide specific details)

_____

_____ _____
Employee signature Date

CHIEF COMPLAINT

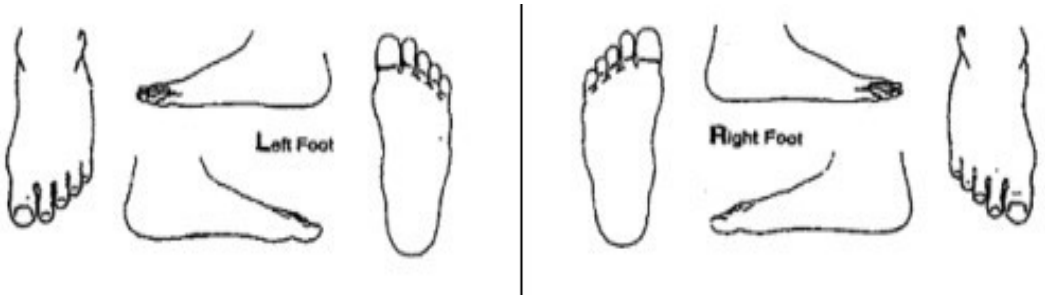
What is your main foot problem today? (Reason for visit) _____

Do you have any other foot problems that need attention? _____

SYMPTOMS OF PRESENT ILLNESS

__ Arch Pain __ Hip Pain __Heel Pain __ Knee Pain __Low Back Pain __Pain in the balls of the feet __ Other _____

LOCATION: MARK ON THE DIAGRAM BELOW THE AREAS WHERE EACH PROBLEM IS LOCATED.



WHAT CAUSED THE PROBLEM?

Trauma? __Yes __NO If yes, what kind? _____

DURATION: when did the problem begin? Date (if known) _____

__ Days __ Weeks __ Months __ Years __ Unknown

What makes it worse? (Example: walking, running, barefoot, wearing shoes, etc.)

_____

_____

What makes it better? (Example: ice, heat, stretching, good shoes, etc.)

_____

_____

QUALITY

__ Burning __ Throbbing __ Sharp __ Dull __Aching __Tingling __Numbness __Itching __ Other _____

SEVERITY (0- NO PAIN, 10- BEING THE WORST PAIN)

0 1 2 3 4 5 6 7 8 9 10

TIMING

__ Gradual __ Sudden __ Unknown

PREVIOUS TREATMENTS: What previous treatments have you used?

Self: _____

_____

Professional: _____

_____

MEDICATIONS:

___ I DO NOT TAKE MEDICATIONS

Medication name	Dosage	How often	Reason for taking

If more space is needed for medication use the back of page or ask for additional paper to continue adding.

ALLERGIES

__ NO KNOWN ALLERGIES

__ Penicillin __ Aspirin __Vicodin __ Tylenol __ Motrin

__ Sulfa __ Advil __ Codeine __ Latex/ Rubber __ Ibuprofen

__Keflex __ Aleve __ Morphine __ Iodine

__ Novocain __ Adhesive Tape __ Metals __ Egg

__ Other _____

MEDICAL HISTORY Please mark if you are currently or previously have been treated for the following

	YES	NO		YES	NO
AIDS/HIV (please specify):			HIGH BLOOD PRESSURE		
ALZHEIMER'S			KIDNEY DISEASE		
DEMENTIA			LEG CRAMPS		
ANEMIA			MULTIPLE SCLEROSIS		
ARTHRITIS			NEUROPATHY		
ASTHMA			PARKINSON'S DISEASE		
LOWER BACK PAIN			POOR CIRCULATION		
BLEEDING DISORDER			SHORTNESS OF BREATH		
CANCER (TYPE):			STROKE		
CONGESTIVE HEART FAILURE (CHF)			SWOLLEN FEET/ ANKLES		
CHRONIC OBSTRUCTIVE PULMONARY DISEASE(COPD)			ULCER (FEET/LEG)		
DIABETES (INSULIN DEPENDENT)			HEPATITIS (TYPE):		
DIABETES (NON-INSULIN DEPENDENT)			HEART MURMUR		
GOUT			HEART DISEASE (TYPE):		

OTHER: _____

_____

SURGICAL HISTORY

__ **NO SURGICAL HISTORY**

TYPE OF SURGERY YEAR

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HISTORY

(PLEASE IDENTIFY TYPE AND WHICH IMMEDIATE BLOOD RELATIVE)

__ARTHITIS: _____ _____

__CANCER: _____ _____

__DIABETES: _____ _____

__HEART DISEASE: _____ _____

__HIGH BLOOD PRESSURE: _____ _____

__NEUROLOGICAL: _____ _____

__OTHER: _____ _____

__ OTHER: _____ _____

SOCIAL HISTORY

USE OF ALCOHOL __ NEVER USED __CURRENT USER __PREVIOUS USER (last time used)_____

USE OF TOBACCO __ NEVER USED __CURRENT USER __PREVIOUS USER (last time used) _____

USE OF CHEWING TOBACCO __ NEVER USED __CURRENT USER __PREVIOUS USER (last time used) _____

USE OF DRUGS __ NEVER USED __CURRENT USER __PREVIOUS USER (last time used) _____

USE OF RECREATIONAL MARIJUANA __ NEVER USED __CURRENT USER __PREVIOUS USER (last time used) _____

USE OF NICOTINE (INCLUDES VAPING) __ NEVER USED __CURRENT USER __PREVIOUS USER (last time used) _____

HEIGHT _____ WEIGHT _____ SHOE SIZE _____

Review of Systems

Please select all that you are currently experiencing.

Constitutional
☐Chills
☐Weakness
☐ Fatigue
☐ Weight Gain
☐ Weight Loss

Head
☐ Dizziness
☐ Pain
☐ Fainting
☐ Headaches

Respiratory
☐ Asthma
☐ Cough
☐ TB
☐ Bronchitis
☐ Wheezing
☐ COPD
☐ Shortness of Breath

Cardiovascular
☐ Cramps in Legs/Feet
☐ Heart Murmur
☐ Leg/Foot Ulcers
☐ High Blood Pressure
☐ Hair Loss on Legs
☐ HX if MI
☐ Replacement Heart Valve
☐ Vascular Grafts
☐ Swelling of Feet/Ankle

Musculoskeletal
☐ Ankle Sprain
☐ Lower Back Pain
☐ Bunions
☐ Gout
☐ High Arches
☐ Flat Feet
☐ Arch Pain
☐ Broken Ankles
☐ Hammer Toes
☐ In-Toeing
☐ Joint Stiffness
☐ Shoe Inserts
☐ Arthritis
☐ Broken Foot Bone
☐ Heel Pain
☐ Knee Pain
☐ Toe Walking
☐Hip Pain

Skin
☐ Dryness
☐ Rash
☐ Ingrown Nail
☐ Fungal Nail
☐ Lumps
☐ Warts
☐ Athletes Foot
☐ Itching
☐Calluses/Corn

Neurological
☐ Burning
☐ Neuroma
☐ Neuropathy
☐ Stroke
☐ Unsteady Gate
☐ Numbness
☐ Tingling
☐ Neuropathy

Endocrine
☐ Fatigue
☐ Thirst
☐ Thyroid
☐ Diabetes