FREELAND
Foot & Ankle
CLINIC

7305 Midland Rd Suite #2
Freeland, MI 48623

www.FreelandFoot.com
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At Freeland Foot and Ankle Clinic, we are committed to providing Mid-Michigan with solutions to foot and ankle problems through compassionate care, customized treatment plans, and state-of-the-art technologies. We are honored that you've chosen us for your foot and ankle needs.
Thank you for being here!

Full name:_____ Today's Date: _____

Age: _____ Date of Birth: _____ Sex: _____ Marital Status: S M W D

Address: _____ Primary Phone #: (_____) _____

City: _____ State: _____ Zip: _____ Secondary Phone #: (_____) _____

E-mail address _____ Preferred Name (if applicable): _____

Occupation: _____ If retired, your former occupation: _____

Patient's Employer: _____ Business Phone: (_____) _____

Spouse: _____ Are they our patient? Yes / No

If under 18 y/o, name of parent/guardian: _____

Relationship to Patient: _____ Responsible parties DOB: _____

How did you hear about our office?

Source		**Source**		**Source**	
Friend / Family	☐	Physician Referral	☐	Online	☐
Radio / Sports Game	☐	Community Event	☐	Other	☐

If you were referred by someone, please leave their name so we can thank them: _____

In case of emergency, notify: _____ Relationship: _____

Phone #1: (_____) _____ Phone #2: (_____) _____

Primary Physician: _____ Last visit: _____

Former Podiatrist Name: _____ Last visit: _____

PHARMACY: _____

Do you give consent to request Rx History from the Pharmacy? ☐ Yes ☐ No
If no, please provide a copy of your prescribed and/or over-the-counter medications

Please list your allergies: _____

Reason for visit: _____

Height_____ Weight_____ Shoe Size_____

Do you have any FOOT or ANKLE pain? ☐ Yes ☐ No ☐ Right ☐ Left ☐ Both

If yes, please explain: _____

Do you wear or have you worn inserts for your shoes? ☐ Yes ☐ No ☐ Prescribed ☐ Over the counter

Please list any FOOT, ANKLE, KNEE or BACK surgeries with approximate date: _____

_____

Please check if you have or had any of the following:

Condition	**Current**	**Previous**	**Condition**	**Current**	**Previous**
Diabetes	☐	☐	Swelling	☐	☐
Kidney Disease	☐	☐	Broken Bones	☐	☐
Liver Disease	☐	☐	Cramps	☐	☐
Arthritis	☐	☐	Ulcer/Wound	☐	☐
Blood Clot/Bleeding Disorder	☐	☐	Neuropathy/ Numbness	☐	☐
Gout	☐	☐	Rash	☐	☐
Raynauds	☐	☐	Dry Skin	☐	☐
Circulation Problems	☐	☐	Cancer: _____	☐	☐
Dementia	☐	☐	Stroke	☐	☐

Other Medical Conditions: _____

If you are diabetic, please provide additional details below:

Do you use insulin? ☐ Yes ☐ No What was your most recent Blood sugar _____

When was your most recent A1C?_____ What was it?_____

Insurance Information / Consent / Authorization

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediary or carriers, or to the billing agent of Freeland Foot and Ankle Clinic, any information needed for this claim. I permit a copy of this authorization to be used in place of the original. I authorize the release of my medical records to and /or from my physician or other health care providers.

Initials: _____
(to be filled out by parent or guardian if patient is under 18 years of age)

Medicare Patients

I request that payment of authorized Medicare benefits be made on my behalf to: Freeland Foot and Ankle Clinic for any service furnished to me by the physician.

Initials:_____
(to be filled out by parent or guardian if patient is under 18 years of age)

Office Cancellation / No Show Policy

Please keep all appointments or call to change an appointment with a 24-hour notice.
I understand that after a missed appointment, one reschedule will be allowed. If additional missed appointments occur, a $30 deposit will be required prior to scheduling another appointment.

Initials:_____
(to be filled out by parent or guardian if patient is under 18 years of age)

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have had the opportunity to read the Notice of Privacy Practices and that I have been offered a copy. It is my understanding that if I have a question, I may contact Freeland Foot and Ankle Clinic for more information.

Initials:_____
(to be filled out by parent or guardian if patient is under 18 years of age)

HIPAA Privacy Authorization:

I give Freeland Foot & Ankle Clinic permission to share my protected health information with:
NAME:_____ RELATIONSHIP:_____
NAME:_____ RELATIONSHIP:_____

FINANCIAL POLICY

Welcome and thank you for choosing Freeland Foot & Ankle Clinic for your healthcare needs. In our effort to provide personalized patient care in the most efficient and economical manner possible, we ask that you take a few moments to read our Financial Policy. Your clear understanding of our Financial Policy is important to our professional relationship. If at any time you have a question regarding our office policies, do not hesitate to contact us, and we will be happy to help you.

Your medical insurance policy is a contract between you and the insurance company. We will work with you to ensure eligibility and to obtain prior authorization, if needed; however, it is ***your responsibility to make sure we are on your insurance plan, if your insurance requires a referral or prior authorization, and to make sure that it is in place prior to your appointment.***

We will bill your insurance company, but ***you are responsible for any patient responsibility established by your health insurance plan, including co-pays, deductibles, and co-insurance amounts, as well as any non-covered services provided to you. If you have an unmet deductible, we may collect an estimated portion of your responsibility (up to 60%) at the time of service, based on your plan's allowable rates.***

If you have a secondary insurance company, we will bill them. If your secondary insurance does not pay the balance within 45 days, the balance will be billed to you and due at that time. If, after all claims are processed, you have a credit on your account, a refund will be issued.

Regardless of the assignment benefits, should the insurance misrepresent their coverage or delay payment of a claim greater than 90 days, ***you are responsible for the amount owed to Freeland Foot & Ankle Clinic. If your insurance carrier later reverses or denies payment for any service, you will be responsible for the resulting balance.***

A consistent attempt will be made to collect outstanding account balances. Past due accounts, more than 100 days, may be turned over to collections, and a 35% fee of the balance due will be added to cover collection costs.

A 24-hour notice is requested for cancellations of all appointments. If you fail to show up for one appointment, we will reschedule and remind you of our policies. If you fail to show up for a second appointment, we will charge a $30 fee that needs to be paid prior to rescheduling.

We accept cash, credit/debit cards, HSA/FSA cards, Care Credit, and personal checks. For your convenience, you may receive a secure text message with a link to pay your balance online. You may also make a payment through our website, over the phone, or in person at our office.

_____ _____

Patient Name (Guardian name if applicable) Date

_____

Signature