7305 Midland Rd Suite #2
Freeland, MI 48623

www.FreelandFoot.com
Ph: (989) 695-6788 Fax: (989) 695-6491

At Freeland Foot and Ankle Clinic, we are committed to getting you back on your feet and back into life! We understand that when your feet hurt, you hurt all over and you stop doing the things you love. We provide the best conservative foot care with the most up-to-date technologies to stop the pain and prevent the injuries which most often begin in the feet! Thank you for giving us the opportunity to serve you.

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 _____

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 practice? _____

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: _____

Other Physician: _____ Last visit: _____

PHARMACY: _____

Reason for visit: _____

In the last few months has there been a change in your:

Weight Work Activity Shoes Flooring at work or home

Height_____ Weight_____ Shoe Size_____

Please list or provide a copy of your prescribed and/or over the counter medicine: _____

_____

_____

Please list your allergies: _____

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

If yes, please explain: _____

Do you have any KNEE, HIP or BACK pain? Yes No Right Left Both

If yes, please explain: _____

Do any of the above problems limit your ability to:
Walk? Yes No Wear shoes? Yes No Work? Yes No

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

Do you have any of the following:

Diabetes	Cancer: _____	Swelling
Kidney Disease	Gout	Broken Bones
Liver Disease	Raynauds	Ulcer / Wound
Arthritis	Neuropathy / Numbness	Cramps
Blood Clot	Dementia	Rash
Bleeding Disorder	Other _____	Dry Skin

Any of these on Feet or Legs:

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?_____

Provider who follows your Diabetic care:_____ Date you were last seen?_____

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

_____

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.

I understand that I am responsible for the payment of charges related to services provided. I also understand that when payment is not made or arrangements for payment are not made by 90 days my balance will be sent to an outside collection company and a 35% charge will be added to my account.

Patient Initials: _____

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.

Patient Initials:_____

Office Cancellation / No Show Policy

Please keep all appointments or call to change an appointment with 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.

Patient Initials:_____

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.

Patient Initials:_____

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 want you to know that **you are responsible for all health insurance co-payments, over the counter items, medical products and non-covered services that apply. We will collect payment at the time of service. If you have an unmet deductible, we pre-collect 60% of the charges incurred that your insurance will apply towards your deductible.** 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.

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.

_____ _____

Patient Name (please print) Date

_____ _____

Parent or Guardian Name (if applicable) Signature