FREELAND FOOT & ANKLE CLINIC PATIENT REGISTRATION
PLEASE FILL OUT THESE FORMS AS COMPLETELY AS POSSIBLE BEFORE YOUR ARRIVAL
**** If you do not have them when you arrive, you may be asked to reschedule your appointment. ****

Patient Last Name **Legal First Name** **MI** **Nickname**

Patient Date of Birth **Age** **Social Security Number** **Gender** ☐ Male ☐ Female **Marital Status** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Address (Not PO BOX) **Apt. #** **P.O. Box (if applicable)** **City** **ST** **Zip Code**

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

May we leave a message? Home YES NO Cell YES NO Work YES NO

Occupation _____ **Employer** _____

☐ **Retired** ☐ **Full Time** ☐ **Part Time** ☐ **Unemployed** ☐ **Disability**

Primary Language ☐ English ☐ Other

Race ☐ Not Specified ☐ White ☐ American Indian ☐ Black/African American ☐ White

Ethnicity ☐ Not Specified ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Family Dr. _____ **Town** _____ **Phone** _____

Insurance Information (We MUST have the Cardholder information)

Primary Insurance _____ **ID #** _____ **Group #** _____ **Co-Pay $**_____

Cardholder Name _____ **Date of Birth** _____

Secondary Insurance _____ **ID#** _____ **Group #** _____ **Co-Pay $** _____

Cardholder Name _____ **Date of Birth** _____

Emergency Contact Person _____ **Relationship** _____ **Primary Phone** (_____) _____ **Secondary Phone** (_____) _____

If you were referred to us by someone, please let us know if there is someone we should thank:

☐ Physician ☐ Family Member ☐ Friend Name: _____

ATTEST: I do hereby attest that this information is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand I am to notify The FREELAND FOOT & ANKLE CLINIC of any changes to the above information and annually upon the request of this office.

Date: _____

Print Patients Name or Legal Representative _____

Relationship to Patient: ☐ Self ☐ Spouse ☐Parent/Guardian ☐ POA

Signature _____

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Please update your email address _____ @ _____. _____

MEDICAL HISTORY

Last Name: _____ Legal First Name _____ Middle Name _____ DOB _____

Are you Diabetic? ☐ Yes ☐ No If Yes, Last A1C _____ When? _____

Physician that follows your Diabetic care _____ Date last seen by them? _____

Height _____ Weight _____ Shoe Size _____

Allergies: Mark NONE if the allergies below do NOT apply to you. _____NONE _____ LATEX

Adhesives/tape Anesthesia Aspirin Blood Thinners Codeine Dairy Eggs Erythromycin Demerol Iodine

IV Contrast Dye Penicillin Seafood Sulfa Vicodin Other: _____

Current Medication: Medication list can be copied and attached separately if available – You do NOT have to rewrite them

Medication	Dosage	How often	Medication	Dosage	How often

Pharmacy _____ **Location**_____ **Phone** _____

Current Conditions: Circle NONE if the following does NOT apply to you.

Symptoms: NONE Chills Fever Nausea Vomiting

Neurological: NONE Numbness/nerve pain Seizures Strokes

Skin: NONE Cellulitis Fungal nails Ingrown Nails Sores Rash Warts

Vascular: NONE Leg/Calf Cramping: with activity at rest Cold Feet/ Toes Skin red/pale/purple

Please describe why you are here to see us today? _____

_____

When did this problem start? _____

Is this from an ☐ injury ☐ accident? What type of accident? ☐ Workplace ☐ Motor Vehicle ☐Other

If yes, Date of injury or accident _____

Have you had previous treatment for this? ☐ Yes ☐ NO If yes, Where: _____

When: _____ By Whom: _____

If yes, please explain: (include medications, therapy, surgery etc.) _____

Patient Name **DOB:**

PAST MEDICAL HISTORY Circle NONE if the history does not apply to you.

AIDS/HIV	Chronic back pain	Gastric reflux	Liver Disease	Seizures
Abnormal heart beat	Chemotherapy	Glaucoma	Lung Disease	Skin disease
Anxiety	Circulation problems	Gout	Multiple Sclerosis	Stroke
Asthma	COPD	Heart Attack	Neuropathy	Thyroid Disorder
Bleeding disorder	Dementia	Hepatitis (Type _____)	Osteoarthritis	Ulcers/sores
Blood Clot	Depression	High Cholesterol	Parkinson's Disease	Other: _____
Cancer type_____	Diabetes I II	High Blood Pressure	Rheumatoid arthritis/Autoimmune disease	

Females Only Are you or could you be pregnant? ☐ Yes ☐ No

Other medical conditions not listed above: _____

_____

Surgical History Do you have any artificial joints? ☐ Yes ☐ No

Please list any surgeries you may have had:

_____ **Year** _____ _____ **Year** _____

_____ **Year** _____ _____ **Year** _____

_____ **Year** _____ _____ **Year** _____

Social History Do you use Tobacco? ☐ YES ☐ NO If Yes, ☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco

Former user? When did you quit? _____

Alcohol History ☐ NONE ☐ Social ☐ Occasional ☐ Heavy Recreational Drug Use Yes No

Family History

☐ **No significant family history**
☐ **Unknown family history**

	Father	Mother	Grandparent
Diabetes	_____	_____	_____
Heart Disease	_____	_____	_____
Arthritis	_____	_____	_____

I have read all of the questions and verify that the information I have given is complete and correct to the best of my knowledge.

Patient Signature _____ **Legal Representative Signature** _____

Date

FREELAND FOOT & ANKLE CLINIC (FFAC) Patient Registration
Authorization from Patient of Legal Representative

1. Consent to Treat: The undersigned consents to any initial or follow-up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, physical therapy, home instructions, orthotics, other durable medical equipment, photographing and/or videotaping and/or other services rendered to the patient by FFAC and its providers. The undersigned agrees that it is their responsibility to contact and/or schedule with FFAC for any follow-up visits, other services, prescriptions and items ordered for the patient. The undersigned also understands that FFAC providers exercise their care with reasonable skill and diligence, but make no guarantee as to the results or cure that will be attained.
INITIAL ____

2. Assignment of Benefits: I hereby irrevocably assign, transfer and convey to FFAC and any practitioner providing care and treatment to me/my child, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I received from The Freeland Foot & Ankle Clinic.
INITIAL ____

3. Medicare Assignment: I certify that the information given by me in applying for payment under XVIII of the Social Security Act is correct and agree to complete the Medicare screening form annually. I authorize the release of information concerning me to the Social Security Administration or its intermediaries as well as any information needed for filing a Medicare claim; I request that payment and authorized benefits be made on my behalf. I assign benefits payable for services to FFAC.
INITIAL ____ NOT APPLICABLE _____

4. Authorization to Release Information: I consent and authorize FFAC and its agents to release my health information for the purpose of payment, treatment, and healthcare operations to any of the following: insurance company and its affiliates, any practitioner, support staff or facility involved in my plan of care or transfer of care. In addition I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy notice. The HIPAA Notice of Privacy Practices is posted in the lobby. Individual copies are available upon request. I have read/had the opportunity to read my HIPAA rights, which include FFAC's fees for records.
INITIAL ____

5. Designation of Authorized Representative: I designate and appoint FFAC (and its agents) as my authorized representative and authorize it to act on my behalf to 1) request and receive a copy of the summary plan description, 2) pursue a benefit claim, 3) appeal and adverse benefit determination, and/or 4) file a legal/equitable action to recover benefits from my employee benefit plan, insurance policy, and any third-party reimbursement or prepaid health care plan. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by me/my child at FFAC, any requests for documents relating to this claim and appeal of an adverse determination of the claim.
INITIAL ____

6. Financial Agreement: I hereby promise to pay for all products received or services rendered to me/my child to the extent I am legally responsible for such payment. According to the language of the physician's insurance contract, I understand that I am responsible for all health insurance copayments, deductibles, coinsurances, OTC-over the counter convenience items and NCS-noncovered services and any other amounts that apply at the time of service or at the pre-operative appointment. Regardless of the assignment of benefits, should the insurance misrepresent their coverage or delay payment of a claim greater than 60 days, as the designated responsible party, I am responsible for all monies owed to FFAC. I also understand that the insurance policy is a contract between me and the insurance company; therefore the policy holder should contact the insurance carrier first when there are questions regarding explanation of benefits.
INITIAL ____

The undersigned certifies that he/she has read and understands the above statements, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms. This document shall remain in force until written revocation by me is delivered to FFAC.

_____ _____
Print Patient's Name or Legal Representative Signature

_____ _____
Relationship to Patient Date

FREELAND FOOT & ANKLE CLINIC
Notification of Office Policies and Procedures

The following notice will keep you informed of our office policies and procedures.

1. **Appointments: Dr. Dailey** will be available by appointment in our office during posted hours. If you have a medical emergency, please go to the nearest Emergency Room or Urgent Care Center or call 911. Payment in full is due when services are rendered unless prior arrangements have been procured.
2. **Missed Appointment**: There will be a $30.00 charge for all appointments missed or cancelled without 24 hour advance notice. If THREE (3) appointments are missed/cancelled, patient may be discharged from our practice.
3. **Late Arrivals:** If you are more than 15 minutes late, you may be asked to reschedule.
4. **Referrals:** The **PATIENT** is responsible for **ALL** insurance prior authorizations and/or referrals necessary for insurance purposes. Patients that do not have a referral will be asked to reschedule their appointment or sign a referral waiver. The referral waiver states that the patient agrees to be **fully responsible for ALL charges** if their referral is not received. **Blue Care Network patients will be required to reschedule their appointment if there is no referral on file.**
5. **Claims Submission:** Our office will file insurance claims as a courtesy to you based on the insurance information provided. This benefit does not release you from your financial obligation related to your account. **All copayments, deductibles and balances must be paid at the time of service.**
6. **Benefits:** It is the patients responsibility to be aware of insurance benefits. We may be able to provide a summary of these benefits upon request. Ultimately, your insurance contract is a relationship between you and your insurance provider.
7. **Self Pay:** Payment in full is due at the time of service if you do not have health insurance. A fee schedule is available. Please contact our office manager for more information.
8. **Payments:** We accept Cash, checks, Visa, MasterCard.
9. **Patient Billing:** You will be sent up to three (3) statements regarding the balance on your account. After the third and last notice, your account may be forwarded to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis.
10. **Returned Checks: There will be a $40 fee on all returned checks.**
11. **Delinquent Accounts:** Past due accounts are subject to collection proceedings and are reported to the credit bureau. All collection fees, attorney fees and court fees shall become the patient's responsibility in addition to the balance due to the office. Patients with a delinquent account must reconcile the account prior to receiving treatment unless their condition is deemed emergent by the physician.
12. **Non-covered Services:** Our office will NOT submit claims to your insurance for non-covered items, including but not limited to: BioFreeze, Urea Care cream, OTC inserts, PowerSteps, Heel cups, PF Sleeves, DM Socks, Surgery Cast Covers, etc. We will provide the patient with a receipt upon request. All OTC items sold are non-returnable/non-refundable.
13. **FMLA/LOA/DISABILITY Paperwork: Patient is responsible for a fee of $25.00 for all forms applicable to these benefits**. Patient is to fill in the necessary information and pay the fee, before paperwork will be completed. Additional charges may apply.
14. **Custom Medical Devices:** You will be notified when your custom equipment is available. The device must be picked up within 30 days of this notification. When you agree to have a custom medical device made, you are agreeing that you will be financially responsible for the cost of the device regardless of insurance coverage. No returns are accepted on custom devices after thirty (30) days of receiving the item(s).

The undersigned certifies that he/she has read and understands the above statements, and is either the patient, or is acting as the general agent of the patient to execute the above and accept the terms.

Print Patients Name or Legal Representative	Signature	Relationship to Patient	Date