Patient Information

Patient Name

First Name | Middle Name | Last Name

Age

Sex:

- Male
- Female
- Other

Pronouns:

- He/Him
- She/Her
- They/Them

Date of Birth:

Month Day Year

Home Address:

Street Address

City

State

Zip Code

Cell Phone:

Area Code | Phone Number

Home Phone:

Area Code | Phone Number

Email Address:

example@example.com

May we send you texts or emails?

- YES
- NO

Marital Status:

- Single
- Married
- Divorced
- Widowed

Employer name/ School name:

Social Security Number:

Please list your family doctor:

Approximate date of last visit:

Month Day Year

If Diabetic, most recent A1C number

Insurance Company:

Emergency Contact (or parent/legal guardian if you are under the age of 18):

Contact Name:

Phone:

Area Code Phone Number

Relation:

Address:

Street Address

State

City

Zip Code

How did you hear about us?

- Google
- Facebook
- Instagram
- Insurance
- Doctors Office
- Friend
- Mailer
-

Which foot do you have complaints about?

- Left foot
- Right foot
- Both Feet

What is the nature of your foot complaint?

What have you done for this condition?

When does it hurt the most?

Approximately when did the condition start?

Preferred Pharmacy:

Are you generally in good health?

- ◯ YES
- ◯ NO

Height:

Weight:

If female, are you now pregnant?

- ◯ YES
- ◯ NO

Shoe size

Past medical history – Do you have or have you had any of the following:

Diabetes

- ◯ YES
- ◯ NO

Acid Reflux (GERD)

- ◯ YES
- ◯ NO

Arthritis

- ◯ YES
- ◯ NO

Asthma

- ◯ YES
- ◯ NO

Back Problems

- ◯ YES
- ◯ NO

Bleeding Disorder

- ◯ YES
- ◯ NO

Hepatitis
- ◯ YES
- ◯ NO

Gout
- ◯ YES
- ◯ NO

High Blood Pressure
- ◯ YES
- ◯ NO

Heart Disease / Heart Attack
- ◯ YES
- ◯ NO

Hayfever
- ◯ YES
- ◯ NO

Nervousness / Anxiety
- ◯ YES
- ◯ NO

Rheumatic Fever
- ◯ YES
- ◯ NO

Depression
- ◯ YES
- ◯ NO

Stroke
- ◯ YES
- ◯ NO

Thyroid Problems
- ◯ YES
- ◯ NO

HIV/AIDS
- ◯ YES
- ◯ NO

Cancer:
- ◯ YES
- ◯ NO

Varicose Veins
- ◯ YES
- ◯ NO

Low Blood Pressure
- ◯ YES
- ◯ NO

Skin Problems:
- ◯ YES
- ◯ NO

Seizures / Seizure Disorder
- ◯ YES
- ◯ NO

Other:

Allergies

Penicillin
- ◯ YES
- ◯ NO

Local anesthetics
- ◯ YES
- ◯ NO

Sulfa
- ◯ YES
- ◯ NO

Codeine
- ◯ YES
- ◯ NO

Aspirin
- ◯ YES
- ◯ NO

Iodine
- ◯ YES
- ◯ NO

Please List the Medications You Currently Take (Include dosage):

Family history (please circle if applicable):

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Bleeding disorder
- ☐ Anesthesia problems
- ☐ Cancer:
- ☐

If Cancer: What kind?

Social history:

Do you smoke?

- ◯ YES
- ◯ NO

If no, have you smoked before?

- ◯ YES
- ◯ NO

If yes, how many packs per day?

How long?

If you have quit, please indicate the date when:

Month Day Year

How often do you drink alcohol?

- ◯ Never
- ◯ Occasionally
- ◯ Moderately
- ◯ History of abuse

Previous Surgeries: (all surgeries - include dates if possible):

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient Name (please print)

Date

Month Day Year

Parent or Authorized Representative (if applicable)

Signature

I hereby authorize Foot and Ankle Clinic to furnish my designated insurance carrier all the information concerning my present illness or injury. I authorize benefits under this claim to be made directly to the physician.

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING:

A) I agree that I am responsible for this debt regardless of my insurance and that I will pay any unpaid balance, in full, within 90 days of the date of billing. I agree to pay 18% interest per annum on the unpaid balance, compounded daily.
B) In the event that my account is not paid as agreed, I agree to pay a collection agency fee of 33.3% of my unpaid balance in addition to my balance, in the event that my account is delinquent.
C) If the account must be referred to an outside collection agency, and you have opted out of receiving a final notice for the delinquent account by text or email, a letter via certified mail or priority mail will be sent. In sending this letter, a fee of up to $6.00 will be added on top of the 33.3% collection fee when the balance is reported.
D) In the event that it is necessary to commence legal action to collect this bill, I agree to pay reasonable attorney's fees and costs of court and agree to submit to the jurisdiction of the Third Circuit Court, Salt Lake City, State of Utah.
E) If any portions of a bill for the provider's services are disputed, I agree to submit myself to mediation or arbitration and will pay the costs incurred in doing so.
F) We want to stay in touch with you regarding your account and its collection status regarding past due balances. In order for us to contact you regarding all past due accounts and any collection status they may have, you expressly authorize us to contact you by the telephone by sending text

messages or e-mails at any number or email you have listed. You acknowledge that such contact could result in charges to you by your telephone carrier. Methods of contact may include the use of pre recorded/artificial voice messages and/or the use of an automatic telephone dialing system, as applicable. You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned.

Signature _____

Date

Month Day Year

Payment Policy

Thank you for choosing Summit Foot and Ankle

- Please be aware that you are fully responsible for your payment to Summit Foot and Ankle.
- **You are responsible to contact your insurance company to verify benefits, coverage, and any limitations for podiatry services.**
- Summit Foot and Ankle may contact your insurance as a courtesy, however we cannot guarantee the accuracy of the information.
- You may request a copy of our full Financial Policy at any time for your records.
- No Show Fee: Patients will be given a courtesy warning on the first occurance of a no show. If a patient does not show a second time, a $50 fee will be charged to the patient. Insurance will NOT cover this fee. If you need to cancel or reschedule, please call the office and let us know.

Based on your insurance plan benefits, if you ...

- Have a Co-payment:
  o It is due at the time of service.
  o You are seeing a Specialist today, therefore you will be charged the Specialist copay amount.
- Have Co-Insurance:
  o We will collect the ESTIMATED co-insurance and bill you for the remaining balance.
- Have a Deductible (that is not met):
  o We may collect $75.00 as a down payment to apply toward your deductible for your visit today.
  o We will then bill you for any remaining balance.
- Do not have insurance:
  o We do offer discounts for Self- Pay patients. Payment for Self- Pay services are due at the time of service.

I (Print Name) , have read and understand the full Financial Policy and the Payment Policy

Patient Signature (Parent/Guardian if under 18):

Date:

Month Day Year

If you have any questions or concerns regarding your account or payment arrangements, please contact your Account Manager, Ally, at 801-218-3338.