



## Patient Information

**Patient Name:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Sex:** M / F / Other **Pronouns:** He/Him She/Her They/Them

**Date of Birth:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**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:** \_\_\_\_\_

**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:** \_\_\_\_\_

**Relation:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

### How did you hear about us?

- |                                    |   |
|------------------------------------|---|
| <input type="checkbox"/> Google    | <input type="checkbox"/> Doctors office _____ |
| <input type="checkbox"/> Facebook  | <input type="checkbox"/> Friend _____         |
| <input type="checkbox"/> Instagram | <input type="checkbox"/> Mailer _____         |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Other _____          |

**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

**If female, are you now pregnant?** Yes  No

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Shoe size** \_\_\_\_\_

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

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease / Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Acid Reflux (GERD)	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness / Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: _____	<input type="checkbox"/>	<input type="checkbox"/>	Seizures / Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems: _____	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
			Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

**Allergies**

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa	<input type="checkbox"/>	<input type="checkbox"/>	Tape / Adhesives / Latex	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

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

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**Family history** (please circle if applicable):

Diabetes      High Blood Pressure      Heart Disease      Bleeding disorder      Anesthesia problems  
Cancer: (what kind?) \_\_\_\_\_      Other: \_\_\_\_\_

**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: \_\_\_\_\_  
How often do you drink alcohol?      Never       Occasionally       Moderately       History of abuse

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

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## Acknowledgement of Receipt of Notice of Privacy Practices

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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

\_\_\_\_\_  
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



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

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

Patient Signature (Parent/Guardian if under 18): \_\_\_\_\_

Date: \_\_\_\_\_

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