Allaire Foot & Ankle, LLC

www.allairefootcare.com

Date_____

Patient Information

Name_____ M / F D.O.B_____ Age_____

Home Phone_____ Cell Phone_____Soc. Sec#_____-____-_____

Address_____ City_____ State_____ Zip_____

Emergency Contact_____ Phone_____Relation_____

Race: __White __Black/African American __Asian __American Indian __Refuse to report

Language: ____English ____Spanish

Ethnicity: __Hispanic/Latino __Non-Hispanic/Latino __Refuse to report

Guarantor Information

Person responsible for Account_____

Relation to patient_____ D.O.B_____ Soc. Sec#____- _____-_____

Address (if different than patient)_____ Phone_____

Employed By_____ Occupation_____

Business Address_____ City_____State_____ Zip_____

Is this an Injury ? Y / N

Date of Accident_____ Type of Accident_____ Employment related?_____

Insurance Information

Must have copy of Insurance cards

Primary Insurance_____

Insured's Name_____ Insured's D.O.B_____

Insured's Soc. Sec#_____-_____-_____ Relationship to Patient_____

Secondary Insurance (if any)_____

Insured's Name_____ Insured's D.O.B_____

Insured's Soc. Sec#_____-____-_____ Relationship to Patient_____

Assignment and Release

I, the undersigned, hereby certify that I (or my dependent), has insurance coverage with the above noted insurance company and assign benefit payments directly to Allaire Foot & Ankle, LLC. I understand that I am financially responsible for all services rendered. I hereby authorize the doctor to release any information necessary to secure payment. I authorize the use of this signature on all insurance submissions. I also understand that it is my responsibility to inform the office if there is a change in my health insurance information that I've provided.

Signature_____ Relationship_____ Date_____

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Patient Medical History

Date_____

Name_____ D.O.B_____

Primary Care Physician_____ Phone_____

Are you presently under the care of a physician? Y / N

If yes, for_____

Please list any and all medications: _____ _____ _____

_____ _____ _____ _____ _____ _____

Pharmacy Name & Location_____

Do you have any allergies? Y / N
If yes, please list_____
(examples: penicillin, lidocaine, codeine, aspirin, food, tape)

Do you smoke? (please circle) Yes No

Present/ Previous Illnesses

Check all that apply

___Cancer
___Diabetes
___Heart Disease
___Asthma
___Liver Problems
___Ear Problems
___Circulation Problems
___Rheumatic Fever Year___
___Tuberculosis
___High Blood Pressure
___Arthritis
___Kidney problems
___Eye Problems
___Excessive Bleeding
___Phlebitis
___Anemia
___Cortisone Treatment

Are you or could you be pregnant? Y / N

Have you been Hospitalized and/or had any Surgeries in the past five years? Y / N
If yes, for _____

What problems are you presently having with your Feet and/or Ankles?

_____

How did you learn about our practice? _____

FINANCIAL POLICY FOR ALLAIRE FOOT & ANKLE, LLC

Thank You for choosing our practice to provide you with medical care. We are committed to serving you with high quality care. Letting you know in advance of our office policy allows for a good flow of communication. If you have any questions please do not hesitate to ask a member of our staff.

INSURANCE: We participate in most insurance plans. If you are insured by a plan we participate with, you will be required to present an up-to-date insurance card. Insurance policies have become increasingly complex over the years making it impossible for our office to know each specific plan and their limitations. Therefore, it is your responsibility to know your insurance benefits. We will submit your claims and assist you in any way we reasonably can to get your claims paid. Your insurance company may need you to supply certain information to them directly. It is your responsibility to comply with their request. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare, as well as your secondary insurance, (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible. Once your deductible has been met, you are responsible for 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance.

COPAYMENTS AND DEDUCTIBLES: All co-payments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATION: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, if you do not have a referral from your PCP at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. If a referral is presented within 48 hours from your visit, a refund will be issued once your visit has been paid. You will also be given the option to reschedule your appointment.

PATIENT BILLING: You will be sent up to three statements for your financial responsibility (co-insurance, deductible) after payment is received from your insurance company. After the third and last statement, your account will be forwarded to collections and a $25.00 administration fee along with 12% interest will be applied. Please let the billing office know if you have any difficulties resolving your bill. We accept Cash, Check , Amex & Visa/MasterCard. An additional $35 fee will be charged for any returned checks. In the event your insurance company should happen to send payment to you, the patient, we expect that you will forward it to our office to be applied to your balance.

PRIVACY STATEMENT: In accordance with the federally mandated program, The Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed. A copy of this Notice of Privacy Practices is offered and available if you so request.

I have read and understand the above Office Financial Policy and agree to comply as outlined above.

PRINT Patient Name	Patient, Parent or Guardian Signature	Date