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__________

Email:____

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 present updated 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: __________________ __________________ ______________
(**or provide list to be copied**)

_________ _________ ______________ ____________ ____________ ______________

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

Shoe size_________ Weight__________

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
___ Cholesterol

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 AND ANKLE, LLC

Thank You for choosing our practice to take care of your podiatric needs. 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.

APPOINTMENTS: We believe your time is as valuable as ours. If you are running late to your appointment , please contact our office as soon as possible. If you are more than 15 minutes late you risk your appointment being rescheduled. There is a NO SHOW fee of $25 which is not covered by insurance and your responsibility.

INSURANCE: We participate with most insurance plans. You will be required to present an up-to-date insurance card at each visit. 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. Please contact your insurance company with any questions you may have regarding coverage.

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

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.

COPAYMENTS AND BALANCES: All co-payments and outstanding balances must be paid at the time of visit.

SELF PAY: Payment in full is due at the time of service.

.**REFERRALS/AUTHORIZATION**: If your plan requires a referral, it is your responsibility to obtain one prior to your appointment.

PATIENT BILLING: You will be sent up to three statements for your financial responsibility after notification is received from your insurance company. After the third notice, your account will be forwarded to collections and a $50 administration fee along with 12% interest will be applied. We accept cash, check and credit/debit cards. A $35 fee will be charged for any returned checks. In the event your insurance company should happen to send payment to you we expect that you will forward it to our office.

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