PATIENT REGISTRATION with Alliance Foot & Ankle Specialists

Use black ink. Submit 2 days prior via HIPAA fax: 877-294-5802

Last Name | **Legal First Name** | **MI**

Physical Address | **City** | **State** | **Zip**

Home Phone (_) ___ -_____ | **Work Phone** (_) ____-_____ | **Cell Phone** (_) __-_____ | **Email**

Date of Birth _____/_____/_____ | **Social Security #** _____-_____ -_____ | **Gender** □ Male □ Female | **Marital Status** □ Single □ Married □ Other

Primary Language | **Race** □ Not Specified □ American Indian □ Asian □ Alaska Native □ Black/African American □ Native Hawaiian □ White | **Ethnicity** □ Not Specified □ Hispanic/Latino □ Not Hispanic/Latino

Employment □ Full-Time □ Part-Time □ Retired □ Unemployed | **Employer Name**

Emergency Contact Name | **Relationship** □ Family □ Friend □ Spouse | **Home Phone** (_) ___ -_____ | **Cell Phone** (_) _-_____

Primary Care Physician | **Office Phone** (_) ___ -_____ | **Referred By** □ Friend □ Insurance □ Internet □ Magazine □ Newspaper □ Phone Book □ Referring Dr

Your claim is □ Compensable/Work Related □ Automobile □ Other Liability □ Not Related Work/Auto/Liability

Primary Insurance– copy of card required for claim

Insurance Name | **Eligibility Phone** (_) ___ -_____

Medical Claims Address

Insured Name | **Relationship to Insured** □ Self □ Spouse □ Child

Insured Date of Birth _____/_____/_____ | **Insured Social Security #** _____-_____-_____

ID # | **Group #**

Insured Employer Name | **Employer/HR Phone #** (_) ___ -_____

Secondary Insurance– only when Medicare is 1st or 2nd

Insurance Name | **Eligibility Phone** (_) _____ -_____

Medical Claims Address

Insured Name | **Relationship to Insured** □ Self □ Spouse □ Child

Insured Date of Birth _____/_____/_____ | **Insured Social Security #** _____-_____-_____

ID # | **Group #**

Insured Employer Name | **Employer/HR Phone #** (_) ___ -_____

Privacy Information

Circle phone number and time of day where we can contact/leave you message(s)? Home: AM/PM Work: AM/PM Cell: AM/PM

Name person(s) who can have access to your records/PHI or pick up items for you:_____

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 that I am to notify Foot and Ankle Associates immediately of any changes to the above information and annually upon the office's request.

_____ _____ _____ _____

Print Name of Patient or Legal Authorized Representative | Signature | Relationship to Patient | Date

Alliance Foot And Ankle Specialists

CURRENT MEDICAL HISTORY

Last Name: _____ Legal First Name: _____ MI: _____

DOB: _____ Age: _____ Gender: □ Female □ Male Weight: _____ Height: _____ Shoe Size: _____

□ PCP or □ Referring Physician: _____ Phone:_____ Date Last Seen: _____

Reason for Visit with Us: _____ Date Occurred: _____

Is your condition □ Work Related □ Automobile Accident □ Other Liability □ Not Related Work/Auto/Liability

Current Problem

Location: (where) □ Bilateral □ Bottom of □ In between □ Inside of □ Left □ Outside of □ Right □ Top of

Site: (what) □ Ankle □ Arch □ Ball of foot □ Calf □ Foot/feet □ Heel □ Hip □ Leg □ Toe(s) □ Toenail □ Other:_____

Quality: □ Achy □ Brittle □ Bruised □ Burning □ Cramping □ Deep □ Dull □ Improving □ Inflamed □ Itching □ Numb □ Pressure □ Red □ Sharp □ Stabbing □ Swollen □ Tender □ Thick □ Tight □ Tingling □ Other:_____

Pain scale:type #__ 0 1 2 3 4 5 6 7 8 9 10 - worst
Severity: □ Mild □ Moderate □ Severe □ Unchanged

Duration: □ Today □ #_____Days □ #_____Week(s) □ #_____Month(s) □ # ____ Year(s)

Timing: □ After exercise □ At night □ Constant □ In AM □ Off and on □ Recurrent □ Other:_____

Cause/Context: □ Fell □ Foot type □ Increased activity □ Injury □ Ortho ≥ 1 yr □ Running □ Standing □ Unknown □ Other:_____

Better with: □ Compression □ Elevation □ Heat □ Ice □ Orthotics □ Shoe gear □ Medication □ Rest □ Other:_____

Worse with: □ Barefoot □ Increased activity □ In shoes □ Pressure □ Running □ Walking □ Other:_____

Also have: □ Arthritis □ Back pain □ Dementia □ Diabetes □ Fatigue □ Headaches □ Infection □ Muscle spasm □ Numbness □ Osteoporosis □ Overweight □ Swelling □ OTC inserts □ Weakness □ Wound □ Other: _____

Current Conditions—mark NONE for each condition that does not apply

Symptoms: □ **None** □ Chills □ Decline in health □ Fever □ Night sweats □ Weight gain □ Weight loss

Eyes: □ **None** □ Blurry vision □ Cataracts □ Eyeglass use □ Glaucoma □ Vision loss

Ears, Nose, Throat: □ **None** □ Dizziness □ Frequent sore throat □ Hearing impairment □ Ringing in Ears □ Sinus Infection

Respiratory: □ **None** □ Asthma □ Cough □ Short of breath □ Sleep apnea □ Snoring □ Wheezing

Heart: □ **None** □ Chest pain □ Extremity cold □ High Blood Pressure □ Heart murmur □ Swelling in legs □ Ulcers on legs

Intestinal: □ **None** □ Abdominal pain □ Constipation □ Diarrhea □ Heartburn □ Nausea □ Vomiting

Musculoskeletal: □ **None** □ Artificial joints □ Gout □ Joint pain □ Muscle cramps □ Soft tissue pain □ Weakness

Psychiatric: □ **None** □ Anxiety □ Claustrophobia □ Depression □ Excessive stress □ Mood swings

Skin: □ **None** □ Eczema □ Ingrown nail □ Lesion □ Nonhealing wound □ Nail appearance change □ Rash □ Ulcer □ Wart

Neurological: □ **None** □ Memory loss □ Migraines □ Numbness □ Paralysis □ Seizures □ Strokes

Endocrine: □ **None** □ Diabetes □ Excessive urination □ Increased thirst □ Thyroid trouble

Hematological: □ **None** □ Anemia □ Bleeding easily □ Blood transfusions □ Easy bruising

Immunologic: □ **None** □ Allergies □ HIV □ Recurrent Infections □ Seasonal allergies

Urinary, Reproductive: □ **None** □ Blood Urine □ Pregnant □ Sexually □ Urinary incontinence

Pharmacy and Current Medications—mark CONSENT for RX history download

□ **Consent for medication history download from pharmacy (limited to certain plans)**

Pharmacy: _____

Street: _____

City/Zip: _____

Phone: _____

Medication	Dose	Frequency	Medication	Dose	Frequency

_____ _____ _____ _____

Print Name of Patient or Legal Authorized Representative | Signature | Relationship to Patient | Date

Alliance Foot and Ankle Specialists

PAST FAMILY SOCIAL HISTORY

Last Name: _____ Legal First Name: _____ MI:____ DOB: _____

Allergies

□ **No Known Drug Allergies** □ Adhesive(tape) □ Amide Anesthetic □ Codeine □ Egg □ Ester Anesthetic □ Heparin
□ Iodine □ Latex □ Milk □ Oak □ Penicillins □ Salicylate (aspirin) □ Shellfish □ Sulfa □ Other: _____

Previous Procedures or Surgeries

□ **No Surgical History**	□ Cesarean section	□ Hip surgery	□ Lower extremity bypass
□ Amputation	□ Coronary bypass	□ Hysterectomy	□ Neuroma
□ Angioplasty/stent	□ Cosmetic surgery	□ Ingrown toenail	□ Pacemaker
□ Appendectomy	□ Gallblader surgery	□ Kidney transplant	□ Steroid injection
□ Blood transfusion	□ Gastric banding	□ Knee surgery	□ Tonsilectomy
□ Bunion	□ Hammer toe surgery	□ Liver transplant	□ _____

Past Medical History

□ **No Known Problems**	□ Cancer	□ GI, stomach ulcer	□ Kidney disease	□ RSD/CRPS reflex
□ Anxiety	□ DVT, blood clot	□ Gout	□ Liver disease	□ Seizure disorders
□ Arthritis	□ Dementia	□ HIV	□ MI, myocardial	□ Stroke
□ Asthma	□ Depression	□ Hepatitis	□ MRSA infection	□ Swelling of legs/feet
□ CAD, coronary artery	□ Diabetes	□ High cholesterol	□ Neuropathy	□ TB, tuberculosis
□ CHF, heart failure	□ Fibromyalgia	□ Hypertension	□ Osteoporosis	□ Thyroid disorders
□ COPD, lung disease	□ GERD, acid reflux	□ Injury of legs/feet	□ Pain of legs/feet	□ _____

Family History

□ Adopted	Alive	Deceased	Arthritis	Cancer	Cholesterol High	Dementia	Depression	Diabetes	Hypertension
□ Father	□	□	□	□	□	□	□	□	□
□ Mother	□	□	□	□	□	□	□	□	□
□ Daughter	□	□	□	□	□	□	□	□	□
□ Son	□	□	□	□	□	□	□	□	□
□ _____	□	□	□	□	□	□	□	□	□

Social History

Smoking History: □ **Never smoked**

Tobacco: □ Cigarettes □ Cigars □ Pipe □ Chew □ Dip

□ Current everyday smoker □ Current some day/social smoker

□ Former smoker □ Smoker: status unknown □ Unknown if ever

□ Heavy smoker (≥10 cig/day) □ Light smoker (≤10 cig/day)

Alcohol History: □ **No history of use**

□ Beer □ Wine □ Hard liquor □ Social □ Occasional

□ Heavy (7≥drinks/week) □ Light (≤7 drinks/week)

Recreational Drug History: □ **No history of use**

□ Have used □ Currently use □ Been treated for substance abuse

Education: □ Grade School □ High School □ College

Occupation: _____

Job requires: □ Climbing stairs □ Lifting+10 lbs
□ Standing □ Traveling □ Walking □ Sitting

Lives with: □ Children □ Friend(s) □ Grandparent(s)
□ Parent(s) □ Partner □ Pet(s) □ Roommate □ Self
□ Sibling(s) □ Spouse Other: _____

Lives in a: □ Home with stairs □ Home without stairs
□ Hospice □ Skilled nursing facility

Activities: □ Aerobics □ Baseball □ Basketball
□ Bowling □ Cycling □ Dancing □ Football □ Hiking
□ Golf □ Gymnastics □ Running □ Soccer □ Swimming
□ Tennis □ Walking □Yoga Other: _____

Print Name of Patient or Legal Authorized Representative	Signature	Relationship to Patient	Date

Alliance Foot & Ankle Specialists **(herein after collectively referred to as "AFAS")**
Notification of Office Policies and Procedures

Reading the following policies and procedures annually will keep you informed about our office.

1. **Appointments:** To allow for greater access of care, our team of physicians is available by appointment during posted hours.
2. **Emergency/after hours**: During a medical emergency, patients should call 911 or proceed to nearest emergency room. On-call physicians should be paged for post-operative complications and other urgent situations.
3. **Refills and Medication**: Refills are completed via a pharmacy request. Contact your plan regarding your drug coverage.
4. **Messages**: Phone messages received before 3 PM are usually returned daily. Emails are returned less frequently.
5. **Benefits**: AFAS will reiterate the benefits that were disclosed to us by your insurance plan. We will then collect based on the benefit level all applicable copays, deductibles, coinsurances and balances that apply at the time of service or at the pre-operative appointment.
6. **Payment**: AFAS accepts VISA, MasterCard, Cash or Checks. All checks are immediately scanned for processing. Our office does not accept temporary checks and we will contact the bank directly to verify checks over $500. In most cases, we do not offer payment plans. We may offer Care Credit for our Laser Service at the 24 month extended payment plan.
7. **Insurance Claims**: AFAS files claims electronically for the patient's primary contracted plan and accepts payment via the patient's assignment. AFAS only files secondary claims for Medicare patients; non-Medicare patients may request itemized statements to file to multiple carriers.
8. **Multiple Policies**: When multiple policies exist, it is the policy holder's responsibility to inform AFAS of their primary plan. Delayed filing to the primary plan can result in violating timely filing limits, resulting in a denial of service and full patient financial responsibility.
9. **Insurance Networks**: AFAS only files claims to carriers whom we have a contractual relationship; our in-network list is available upon request or on our website. We are not contracted with any Medicare replacement plans.
10. **Liability Claims**: AFAS does not accept workers compensation, personal injury protection, and letters of protection or other liability claims. These types of claims are to be paid in full by the patient.
11. **Non-Covered Services:** AFAS will not submit claims for non-covered items including, but not limited to cosmetic services and over the counter convenience items (OTC eg. Biofreeze, Coban, Lyncos, Mycomist, etc…)
12. **Referrals**: AFAS may refer patients to other providers, facilities, and labs. AFAS is not responsible for these entities. The patient should contact these non-AFAS providers, facilities or labs directly regarding any billing questions. The policy holder is also responsible for all insurance prior authorizations and/or managed care referrals necessary for payment to AFAS.
13. **Missed Appointments**: A $40 charge will apply for appointments broken or canceled without 24 hours advanced notice.
14. **Appointment Hold**: Repetitive broken appointments, non-compliance, hostile behavior, and/or financially deficient accounts will result in appointment hold and/or the termination of the Foot and Ankle Associates of North Texas Doctor-Patient relationship. 30 days' advance notice will be given should the situation result in a transfer of the patient's care.
15. **Patient Balance Statements**: AFAS will send a remainder or balance statement to the patient when the benefits have been misrepresented by the carrier. Each statement will be accessed a $10 rebilling fee for each month that it is reissued.
16. **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/guarantor's responsibility in addition to the balance due the office.
17. **Returned Checks**: A $30.00 fee will be assessed on all returned checks. Any NSF or Closed Account will result in future services on a pre-pay cash or credit basis. The District Attorney's Office will prosecute unresolved checks.
18. **Refunds**: AFAS issues patient refunds by check within 30 days of a completed investigation of the potential overpayment, as long as other outstanding accounts have been resolved.
19. **Returns**: Only unworn and non-custom items are returnable within 14 days of receipt, if no visible signs of wear, tear, or odor. Custom items are tailored to meet individual needs; custom items are non-returnable, non-refundable.
20. **Medical Records**: The cost for copied medical records and completion of disability forms will be charged to the patient and collected prior to replicating. The fees for these services are regulated by HIPAA and Texas Health and Safety Code.
21. **Secure Portal**: Patient messaging, instructions, clinical summaries, and patient records are provided on line.

The undersigned certifies that he/she has read and understands the foregoing 1-20 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.

Print Name of Patient or Legal Authorized Representative	Signature	Relationship to Patient	Date

Alliance Foot and Ankle Specialists (herein after collectively referred to as "AFAS")

1. **Consent to Treat:** The undersigned consents to any initial or follow-up evaluations, examinations, x-rays, laboratory procedures, other test, 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 AFAS and its providers. The undersign agrees that it is their responsibility to contact and/or schedule with AFAS for any follow up visits, other services, prescriptions and items ordered for the patient. The undersigned also understands that AFAS's providers exercise their care with reasonable skill and diligence, but make no guarantee as to the results or cure that will be attained.

2. **Assignment of Benefits:** I hereby irrevocably assign, transfer and convey to AFAS 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 AFAS.

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 AFAS.

4. **Authorization to Release Information:** I consent and authorize AFAS 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 are available online at **www.footdoc.org.** Individual copies are also available in the office and posted in the lobby. I have read /had the opportunity to ready my HIPAA rights posted in the lobby. I have read/had the opportunity to read my HIPAA rights. The fees to release information is $25 for records.

5. **Designation of Authorized Representative:** I designate and appoint AFAS (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 AFAS, any requests for documents relating to this claim and appeal of an adverse determination of the claim.

6. **Financial Agreement:** I hereby promise that premiums for my insurance are kept current. Furthermore, I agree to pay for all products received or services rendered to me/my child to the extent I am legally 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. Should the insurance misrepresent their coverage or delay payment of a claim greater than 45 days, as the designated responsible party, I am responsible for all the monies owed to AFAS. 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.

The undersigned certifies that he/she has read and understands the foregoing statements 1-6, 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 a written revocation by me is delivered to AFAS.

Print Name of Patient or Legal Authorized Representative	Signature	Relationship to Patient	Date