Anchorage Foot and Ankle Clinic
1000 E Dimond Blvd Ste 201
Anchorage, AK 99515

Patient Name: _____DOB: _____

If the patient is underage or has a POA or Guardian please provide POA/Guardian/Parents name:
_____

Primary Billing Address:_____
Patient/POA/Parent/Guardian Phone Number:_____

Email address: _____

Race: White, Black, Asian, Other (circle one)
Ethnicity: Hispanic or Not- Hispanic (Circle one)
Language: English, Spanish, Other (circle one)

Referral source (Who can we thank?): _____

Who is you Primary Care Physician (PCP)?:_____
Clinic where they are located: _____

Insurance:

Primary Insurance Name: _____
Main member name: _____
The main members date of birth: _____
Prefix:_____ Identification #/Subscriber #_____
If you are Tricare or VA (Triwest), provide the main members social security #_____

Secondary Insurance Name: _____
Main member name: _____
The main members date of birth: _____
Prefix:_____ Identification #/Subscriber#_____
If you are Tricare or VA (Triwest), provide the main members social security #_____

Please provide your insurance card and drivers license so we can make a copy for your file.
Assignment of Benefits: (Allows us to file with your insurance) I hereby assign all medical, to include major medical benefits to which I am entitled including Medicare and private insurance and any other health plans to: Anchorage Foot and Ankle Clinic, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. I authorize Anchorage Foot and Ankle Clinic, LLC to download my medication history and Rx benefits into my account from a Rx clearing house.

Signed:_____ Date:_____

Medical History

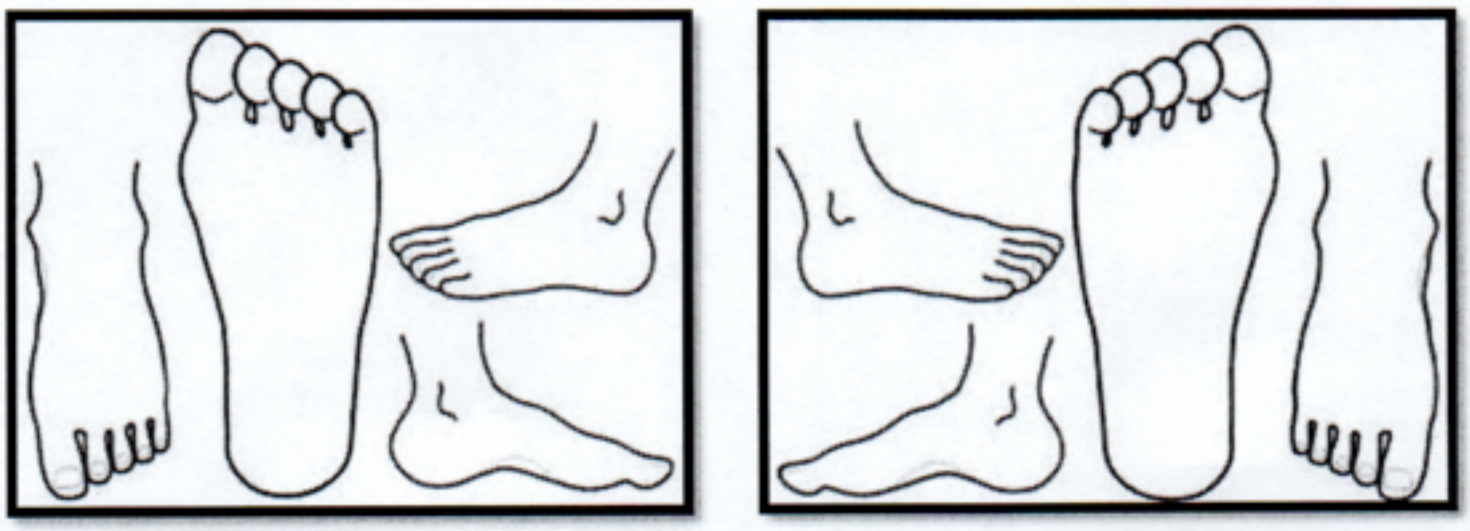
Patient Name: (Last, First, MI) _____DOB: _____

Pharmacy you use: _____
Height: _____Weight: _____Shoe Size: _____Width: _____Do you wear Orthotics? Yes or No

What is the chief complaint for which you came to be treated?

_____

Location: (Circle) Left foot/ankle Right foot/ankle



When did the symptoms start? _____ How did it start? _____
Made worse or better by:_____
Previous Imaging: (X-rays, MRI, etc.) Yes / No Where/When was it completed: _____

Please indicate which foot problems you now have or have had in the past.

Foot/Ankle Pain	Yes / No	Bunions	Yes / No	Tired Feet	Yes / No
Corns or Calluses	Yes / No	Numbness	Yes / No	Swelling	Yes / No
Flat Feet	Yes / No	Foot/Leg Cramps	Yes / No	Heel Pain	Yes / No

Cigarette/Tobacco use? ( ) Never ( ) Previously; quit what year? _____ ( ) Current; _____ packs per day
Do you drink alcohol? ( ) No ( ) Daily ( ) Weekly ( ) Monthly For how many years? _____
Do you use recreational drugs? ( ) Yes ( ) No What kind?_____ For how many years? _____

Allergies: (*Circle all that apply*) ( ) No known drug allergies

Food:	Drug:	Environmental:
Gluten	Anticoagulant Therapy	Adhesive/Tape
Milk/Dairy	Aspirin	Dogs/Cats
Peanut	Codeine	Nickel
Seafood	Demerol	Pollen
Soy	Iodine	Mold
Eggs	Sulfa Drugs	Latex
Other: _____	Other: _____	Other: _____

Current Medications: (Include prescriptions, over the counter, and vitamins). ( ) I don't take any medication

Name:	Dosage:	Reason for use:

Medications continued:

Name:	Dosage:	Reason for use:

Past Surgical History: (Include **ALL** previous surgeries you have had).

Surgery:	Date:

Have you ever been hospitalized? ( ) Yes ( ) No For what? _____ Date: _____
Have you ever had any post-operative infections? ( ) Yes ( ) No
Have you had MRSA? (Antibiotic resistant staph infection) ( ) Yes ( ) No
Are you currently pregnant? ( ) Yes ( ) No

Health History: (Please circle all diseases or disorders you have now or experienced in the past).

Cardiovascular:	**Dermatologic:**	**Eyes:**	**Psychiatric:**
Arrythmia	Callus	Cataract	Alcohol Abuse
Blood Clots	Cellulitis	Glaucoma	Anxiety
CHF	Rash	Diabetic Retinopathy	Depression
Heart Disease	Skin Lesion	**Hematologic/ Lymphatic:**	PTSD
High Blood Pressure	Ulceration	Anemia	Sleep Difficulty
High Cholesterol	Warts	Pulmonary Embolus	ADD/ADHD
Lymphedema	**Endocrine:**	Blood Clotting Problems	**Constitutional:**
Peripheral Vascular Disease	Diabetes Type I	**Musculoskeletal:**	Fever
Stroke	Diabetes Type II	Gout	Weight Loss
Low Blood Pressure	Hyperthyroid	Joint Pain	Weight Gain
Stroke	Hypothyroid	Muscle Weakness	Fatigue
Other: _____	Pre-diabetes	Osteoarthritis	**Respiratory:**
ENT:	**Gastrointestinal:**	Scoliosis	COPD
Acid Reflux	GERD	Spinal Stenosis	Asthma
Sleep Apnea	Hepatitis A, B, or C	Swelling	Emphysema

Anything additional health issues not listed above: _____

Family History: (Please circle whether anyone in your immediate family has ever experienced any of the following)
M= Mother, F= Father, S= Sibling

Heart Disease	M F S	Arthritis	M F S	Diabetes	M F S
High Blood Pressure	M F S	Cancer	M F S	Liver Disease	M F S
Bleeding Problems	M F S	Osteoporosis	M F S	Stroke	M F S
Diabetes	M F S	Stroke	M F S	Other: _____	M F S

I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet/ankles.

Patient Signature: _____ Date: _____

ANCHORAGE FOOT AND ANKLE CLINIC LLC
STATEMENT OF BILLING/CREDIT/NOTICE OF INFORMATION POLICIES FOR THE BENEFIT OF OUR PATIENTS

Contracted Insurance plans:

We accept payment based on Insurance Company's allowable fee structure and the contract your insurance group has with the carrier. Any allowable balances are the responsibility of the patient and are due in full upon receipt of statement.

It is not possible for Anchorage Foot and Ankle Clinic to know the specific benefits of your plan. It is your responsibility to be aware of your coverage and to ensure that your bill is paid.

The Patient is responsible for all account balances, even with insurance benefits. We will bill your insurance as a courtesy to you, but we cannot guarantee your benefits. If your insurance company informs us of any benefits you are, or are not entitled to, we will advise you of the same. Any oral representation we make in good faith to you concerning your insurance is not binding on us and will not in any way or for any reason be considered a modification of this billing notice.

INSURANCE CO-PAYMENTS:

Co-Payments are due at check-out from your appointment. Your co-payment is determined by your insurance plan, Anchorage Foot and Ankle Clinic LLC in no way determines your co-pay amount and is required to collect your co-pay at time of visit.

We accept cash, personal checks, Mastercard /Visa.

MEDICARE:

We accept assignment for our Medicare patients, and we will bill Medicare for you. Do not submit the claim yourself. Medicare pays 80% of their allowable fee after you have satisfied your deductible amount. If you have supplemental insurance, we are required to provide this information to Medicare. In most cases, Medicare will bill your claim to your supplemental insurance for you.

Medicare does not pay for orthotics. Patients must also meet very specific requirements for Medicare to cover foot/nail care and is only covered every 61 days. It is the patient's responsibility to pay for services not paid for by Medicare. You will be asked to sign a waiver, when appropriate, indicating that you have been informed that Medicare may not cover certain services and that you as the patient accept financial responsibility.

No-Show appointments:

Patients who fail to cancel their office visit appointments without 24 hours' notice will be charged $50.00 for the first time and $75.00 for each time after that. Surgeries/Office Procedures will be charged $200 for a missed appointment. Patients that miss three appointments without giving notice will be dismissed from Anchorage Foot and Ankle Clinic.

Fees:

Patient's will be charged an administrative fee of $25 for us to complete FMLA, disability, or job-related forms. A fee of $5 will be charged for copies of X-Rays. If your account is sent to collections for non-payment, you will incur a $50 service fee.

I have read and understand this policy and acknowledge full responsibility for the payment of services rendered. I authorize all payments to be made directly to Anchorage Foot and Ankle Clinic LLC, or my provider on my behalf for any services or supplies furnished by my doctor or Anchorage Foot and Ankle Clinic LLC and for my doctor to act as my agent to help obtain payment. I authorize the release of medical information or documentation in their possession about me to all my insurance companies as well as to Medicare in order to determine benefits of the benefit payable for related services, now or in the future.

Signature_____ Date_____

Name (Print)_____

Feb-19

Anchorage Foot and Ankle Clinic LLC

Patient Consent For The Use And Disclosure Of Protected Health Information

I hereby give my consent to Anchorage Foot and Ankle Clinic LLC to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Health Care Operations (TPO). Anchorage Foot and Ankle Clinics LLC Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Anchorage Foot and Ankle Clinic LLC reserve the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy may be obtained by forwarding a written request to: Anchorage Foot and Ankle Clinic LLC, Privacy Officer, 1000 E Dimond Blvd Suite 201, Anchorage, AK 99515.

With this consent, Anchorage Foot and Ankle Clinic LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Anchorage Foot and Ankle Clinic LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Anchorage Foot and Ankle Clinic LLC may e-mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Anchorage Foot and Ankle Clinic LLC restrict how it uses or discloses my PHI to carry out TPO.

However, this practice is not required to agree to my request restricting, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Anchorage Foot and Ankle Clinic LLC's use and disclosure of my PHI to carry out TPO.

I may revoke consent in writing except to the extent that this practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Anchorage Foot and Ankle Clinic LLC may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____

Patients Name

_____ _____

Print Name of Patients Name or Legal Guardian Date

WAIVER
Splinting, Orthotics, DME and other Supplies
Notification to Patient

During your course of treatment with Anchorage Foot and Ankle Clinic LLC, you may require splinting, orthotics and/ or other DME (durable medical equipment) that are not a covered benefit under your insurance plan. Surgical shoe/removable casts will be billed to your insurance, they may or may not be a covered benefit.

If you order/receive orthotics, we will require a $100.00 down payment at the time of service. The down payment is non-refundable. We will then bill your insurance company for you. The fee for orthotics is $500.00. It is your responsibility to call your insurance regarding coverage. Custom fit orthotics are non-returnable and non-refundable once order is placed.

I, _____, have been informed by Anchorage Foot and Ankle Clinic LLC that the item(s) I may receive during my course of treatment may not be a covered benefit under my insurance plan. If it is not a covered benefit, I am responsible for payment of the supply item.

Patient (or guardian) signature_____
Date_____

Please be advised, you may or may not receive these supplies. This is only a waiver

12/2019

Medical Information Release Form - HIPAA

Name of patient: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including my diagnosis, records, examinations rendered to me and claims information. This information may be released to:

( ) Myself

( ) My Spouse _____
(their name)

( ) My Child(ren)_____
(their name/s)

( ) My Primary Care Physician_____
(their name)

( ) Other_____
(their name)

( ) Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

My signature: _____

Today's date: _____

If this form is being completed by a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing the form: _____

Relationship to patient: _____

Signature of person completing this form: _____

Date signed: _____

12/2018