ANCHORAGE
FOOT & ANKLE CLINIC

Patient Information Form

Name – First: _____ Last: _____ M.I.:___

Nickname: _____ Date of Birth: _____ Gender: M / F

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Number: _____

Email: _____

Parent/Guardian/Spouse (**Primary Insurance Holder**)

Name – First: _____ **Last:** _____ M.I.:___

Date of Birth: _____ Gender: M / F SSN (military): _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Number: _____

email: _____

Primary Medical Insurance

Insurance Company: _____ ID#: _____

Policy Holder: _____ Group #: _____

Secondary Medical Insurance

Insurance Company: _____ ID#: _____

Policy Holder: _____ Group #: _____

Referral Source (Who may we thank?): _____

Primary Care Physician: (Name and Clinic) _____
Date last seen by PCP: _____

Do you see any other providers? If so, who and what type of specialty?

_____

_____

_____

_____

1000 E Dimond Blvd, Ste 201
Anchorage, AK 99515

(907) 344-2155 Phone
(907) 344-8841 Fax

www.anchoragefootankle.com

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Billing Policies

Agreement to Pay for Treatment:

I hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with which this office has a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. I further agree to pay for treatment rendered to the patient which is not considered to be a covered service by my insurer. A third-party insurer or other payer. I understand that not paying for treatment will lead to my account being sent to collections and being dismissed from AFAC.

Financial Responsibilities:

I understand that it is my responsibility to:

- provide AFAC with correct insurance information for billing purposes
- contact my insurance company to verify my benefits
- respond to all requests for information I may receive from my insurance company
- pay all co-payment or co-insurance amounts at time of service
- pay all balances not paid by my insurance company, immediately upon receipt of a bill from AFAC

Payment for DME:

I understand that **splinting, orthotics and other durable medical equipment** (DME) that the patient may receive during the course of treatment **may not be a covered benefit** under my insurance plan. I understand that supply costs not covered by my insurance are my responsibility and I agree to pay for these supplies.
I understand that if orthotics are ordered for the patient, I will be responsible for $150.00 deposit that may be refunded to me once my insurance pays for the orthotic.
I understand it is my responsibility to contact my insurance regarding coverage for Orthotics/DME.
I understand the fee for custom fit orthotics is $550.00 which is **non-returnable and non-refundable once an order is placed**.
I understand that if Orthotics are not picked up within 30 days, they will be mailed to me at my own expense.

Assignment of Benefits:

I hereby assign all benefits, in include major medical benefits, to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, auto, or any other health/medical plan, to issue payment check(s) directly to AFAC for medical services or supplies rendered to myself or my dependents regardless of my insurance benefits, if any. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for any amount not covered by my insurance.

Patient Name: _____ Date of Birth: _____

_____ _____
Patient Signature Date

_____ _____
Responsible Party Signature Date

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Billing Notices

No Show:

I understand that if I fail to cancel my office visit appointment without 24 hours prior notice, I will be charged $50.00 for the first appointment and $75.00 for each appointment after.

I understand that if I fail to cancel my surgery or office procedure without 24 hours prior notice, I will be charged $200.00 for the missed appointment.

I understand that if I No Show for three appointments I will be dismissed from AFAC.

Additional Fees:

$50.00 – Service fee if account is sent to collections
$25.00 – Service fee for NSF check returns from your bank
$25.00 – Administrative fee for completion of forms, including FMLA, Disability, or other job-related
$5.00 – Copy fee for x-rays

Medicare:

I understand that if I have Medicare that AFAC bills Medicare for me and I do not need to submit a claim myself. I understand that Medicare pays 80% of the allowable amount after I have met my deductible. It is my responsibility to pay for the remaining amount.
If I have Medicare supplemental insurance, it is my responsibility to provide this information to AFAC prior to receiving treatment.

I understand that **Medicare does not pay for Orthotics** and that I will need to meet specific Medicare requirements to have my foot/nail care covered. If covered, these services will only be paid by Medicare every 61 days. I understand that it my responsibility to pay for services not covered by Medicare. An Advanced Beneficiary Notice will be supplied to me when appropriate to help me make an informed decision about payment of my medical care.

Payment at Time of Service:

I understand that AFAC expects payment at time of service for all co-payments, co-insurance, or non-covered services.
AFAC accepts cash, personal checks, Mastercard and Visa

Patient Name: _____ Date of Birth: _____

_____ _____
Patient Signature Date

_____ _____
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Authorizations to Release Information

I hereby authorize AFAC to release protected health information (PHI) necessary to assist in the reimbursement of benefits of which I may be entitled.
I hereby authorize AFAC to request/release PHI necessary to assist in my medical treatment (including other medical providers I see, hospitals, facilities, etc.)

I hereby authorize AFAC to disclose **my health information** to: _____

Relationship: _____
This authorization is effective from the date of signature until _____, or until I revoke this authorization, whichever is soonest.

I hereby authorize AFAC to disclose **my health information** to: _____

Relationship: _____
This authorization is effective from the date of signature until _____, or until I revoke this authorization, whichever is soonest.

I hereby authorize AFAC to disclose **ONLY my Billing information** to: _____

Relationship: _____
This authorization is effective from the date of signature until _____, or until I revoke this authorization, whichever is soonest.

_____ _____
Patient Signature Date

I hereby authorize AFAC to *(initial each item being authorized)*

_____ Leave a detailed message on my Cell Phone:_____
_____ Leave a detailed message on my Home Phone: _____
_____ Leave a detailed message on my Work Phone:_____
_____ Send me detailed appointment reminder information to my Cell (Text)
_____ Send detailed information regarding my health and/or appointments to my Email: _____
_____ Send detailed information to me via Mail
_____ Download my medication history and prescription benefits into my clinic account

The AFAC Notice of Privacy Practices is available for your review on our website or in the binder in our lobby. The Notice provides a detailed description of what we do with your protected health information. It also explains your rights for getting access to that information and controlling its use and disclosure.

I understand that I have been offered a copy of AFAC's Notice of Privacy Practices.

_____ _____
Patient/Responsible Party Signature Date

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Patient Name: _____ Date of Birth: _____
Height: _____ Weight: _____
Shoe Size: _____ Width: _____ Do you wear Orthotics? Yes / No
Preferred Pharmacy: _____
Primary Care Physician: _____

Medical History: *List any major medical conditions including those for which you take medication*

If you have Diabetes: Recent Hemoglobin A1c _____ Recent blood sugar: _____

Current Medications: *List Name and Dosage*

Allergies: *List allergen and reaction*

Past Surgical History: *Within past 10 years- List surgeries & approximate year*

Do you smoke cigarettes or vape? Yes / No *If yes*, current # of packs per day? ____

Do you drink alcohol? Yes / No *If yes*, number of drinks per week? _____

Do you use recreational drugs? Yes / No *If yes,* which? _____

Hospitalization History:_____

Have you ever had post-operative infection? Yes / No

Have you had poor wound healing? Yes / No

Do you have a pain contract with a pain management provider? Yes / No
If so, who is your provider?_____

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What is the primary reason for evaluation today?

_____

_____

_____

Have you had previous imaging regarding this issue? (X-rays, MRI, etc.) When/Where?

_____

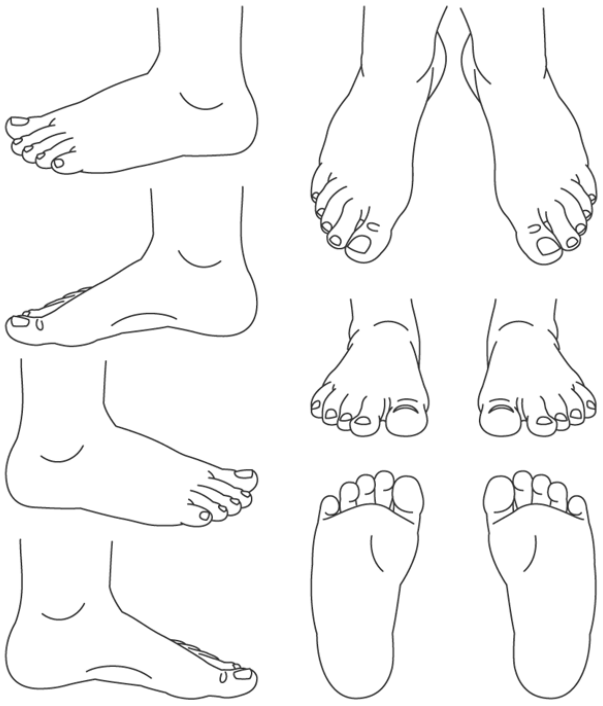
Do you have any of the following symptoms currently or have you within the last 6 months? (*Indicate Right/Left/Both*)

_____	Foot/Ankle Pain	_____	Heel Pain
_____	Foot/Leg Cramps	_____	Swelling in Foot/Ankle
_____	Bunions	_____	Corns/Calluses
_____	Tired Feet	_____	Numbness in Foot
_____	Flat Feet	_____	High Arch
_____	Ingrown Nails	_____	Fungal Nails
_____	Leg/Foot Ulcers	_____	Broken Foot/toe

Do you get leg cramps after activity? Yes / No
Does foot pain limit your desired activities? Yes / No
Do you have difficulty walking or are you limping? Yes / No
What sports/activities are you involved in:

_____

Indicate the location of your problem or pain on this diagram:



Does the pain radiate to elsewhere on your foot/leg? Please describe:

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