Registration Form

FAMILY FOOT AND ANKLE CLINIC

P: 715-241-8100 ~ F: 715-241-8102

www.familyfoot.org

WESTON MARATHON ANTIGO MERRILL WAUSAU WOODRUFF SHAWANO STEVENS POINT WAUPACA

Patient Information

Patient Name (Last, First, MI)

_____

Address_____

City, State, Zip _____

Email _____

Home Phone_____

Cell Phone _____

Birthdate _____ Age _____Sex_____

Race _____Social Security # _____

Work*(Circle):* Full-time Part-time Retired Unemployed Student

Place of Employment: _____

Work Phone _____

Marital Status: Married, Divorced, Single, Widow

Billing Address/Responsible Party/Guardian/POA:

Name _____ DOB: _____

Relationship to patient _____

Address _____

City _____State _____ Zip _____

Home Phone _____

Cell Phone _____

Emergency Contact: _____

Emergency Contact Phone: _____

Podiatric History

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

_____

_____

On a scale of 1-10 rate your pain; 1 = minimal & 10 = extreme:

1 2 3 4 5 6 7 8 9 10

Have you seen a podiatrist before? ☐ **No**

☐ **Yes** - Name _____Last Visit _____

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

Ankle Pain	Heel Pain	Gout
Athlete's Foot	Ingrown Toenails	Tired Feet
Bunions	Neuropathy	Flat Feet
Corns & Calluses	Numbness in Feet/ Legs	Plantar Warts
Foot/ Leg Cramps	Swelling in Ankles/ Feet	Plantar Fasciitis

Referred by_____ **Date Seen**_____

How did you hear about us? (Please circle)

Friend/Family TV/Radio Internet/ Social Media News/Article

Word of Mouth Other: _____

Height_____ **Weight**_____ **Shoe Size**_____

FLU VACCINATION: ☐ Yes ☐ No Year: _____

PNEUMONIA VACCINATION: ☐ Yes ☐ No

Do you have a living will or someone to make decisions on your behalf?

☐ Yes ☐ No

Treatment Consent

I hereby consent and give my permission to the doctor (and the doctor's assistant or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

→ _____ _____

Signature of Patient, Parent, Guardian or Personal Representative ***Date***

Insurance Information

Subscriber Name _____

Relationship to Patient _____

Subscriber DOB_____ SSN _____

Insurance Company _____

Group _____

Subscriber ID _____

Secondary Insurance

Subscriber Name _____

Relationship to Patient _____

Subscriber DOB_____ SSN _____

Insurance Company _____

Group _____

Subscriber ID _____

Insurance Assignment and release

I certify that I have insurance coverage with the above insurance company(ies) and assign directly to the Family Foot and Ankle Clinic, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. FFAC may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Medicare/Medigap Authorization

I request that payment of authorized Medicare/Medigap benefits be made on my behalf to Family Foot and Ankle Clinic LLC for any services furnished to me by their providers. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the centers for Medicare and Medicaid services, my Medigap insurer, and their agent, any information needed to determine these benefits or benefits for related services.

→ _____ _____

Signature ***Date***

Relationship to Beneficiary _____

Medical History								
AIDS/HIV	___Yes	___No	Epilepsy	___Yes	___No	Psychiatric Care	___Yes	___No
Allergies to anesthetics	___Yes	___No	Eye Problems	___Yes	___No	Radiation treatment	___Yes	___No
Anemia	___Yes	___No	Fainting	___Yes	___No	Rash	___Yes	___No
Angina	___Yes	___No	Gout	___Yes	___No	Respiratory disease	___Yes	___No
Arthritis	___Yes	___No	Headaches	___Yes	___No	Rheumatic fever	___Yes	___No
Artificial heart valves/joints	___Yes	___No	Heart disease	___Yes	___No	Shortness of breath	___Yes	___No
Asthma	___Yes	___No	Hemophilia	___Yes	___No	Sinus problems	___Yes	___No
Back Problems	___Yes	___No	Hepatitis/jaundice	___Yes	___No	Special diet	___Yes	___No
Bleeding Disorders	___Yes	___No	High blood pressure	___Yes	___No	Stroke	___Yes	___No
Cancer	___Yes	___No	High cholesterol	___Yes	___No	Swollen neck glands	___Yes	___No
Chemical Dependency	___Yes	___No	Insomnia	___Yes	___No	Thyroid disease	___Yes	___No
Chest Pain	___Yes	___No	Kidney Problems	___Yes	___No	Tuberculosis	___Yes	___No
Chronic diarrhea	___Yes	___No	Liver Disease	___Yes	___No	Ulcers	___Yes	___No
Circulatory Problems	___Yes	___No	Low Blood Pressure	___Yes	___No	Varicose veins	___Yes	___No
Diabetes/**A1C:**_____	___Yes	___No	Nervous Problems	___Yes	___No	Venereal disease	___Yes	___No
Type 1___ Type 2___			Osteoporosis	___Yes	___No	Unexplained weight loss	___Yes	___No
Ear Problems	___Yes	___No	Phlebitis	___Yes	___No	OTHER:_____		

Other Medical History (not listed above):_____

Family Physician: _____ **Date of last visit**: _____

Have you ever smoked: ☐ Never ☐ Former ☐ Currently – How often: _____ ☐ Chewing Tobacco
Alcohol Consumption: ☐ No ☐ Yes → **How Often:** ☐ Rarely ☐ Occasionally ☐ Socially ☐ Moderately ☐ Daily
Illicit/Illegal Drug Use: ☐ No ☐ Yes

Exercise/Athletic Activities: _____

Surgeries: ☐ None

☐Foot –Right or Left _____ ☐Ankle-Right or Left_____ ☐Knee-Right or Left_____
☐Hip ☐Back/Apine ☐Heart Surgery(ies)
☐Hysterectomy ☐Appendix Removal ☐Hernia
☐Gall Bladder Removal ☐Thyroid ☐Tonsillectomy
☐Pacemaker ☐Stent Placement ☐Other:_____

Medications & Dosages: ☐ I do not take medications

_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies: ☐ None ☐ Adhesive Tape ☐ Latex ☐ Sulfa ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Iodine ☐ Vicodin
☐ Others: _____

Family History: * ☐ Adopted ☐ I have no family medical history

Arthritis: ☐ Mother ☐ Father * Cancer: ☐ Mother ☐ Father * Diabetes: ☐ Mother ☐ Father

Heart: ☐ Mother ☐ Father * Hypertension: ☐ Mother ☐ Father * Stroke: ☐ Mother ☐ Father

REVIEW OF SYSTEMS

Patient Name: _____

Please check any of the following that you are **currently experiencing** or have **recently experienced.**

Constitutional			
☐ Fever	☐ Chills	☐ Sweats	☐ Weight Change
Head, Eyes, Ears, Nose and Throat			
☐ Wear Contact Lenses	☐ Dentures	☐ Wearing Eyeglasses	
☐ Double Vision	☐ Cataract	☐ Dizziness	
☐ Difficulty Swallowing	☐ Neck Pain	☐ Sore Throat	
☐ Nosebleeds	☐ Problems with eyesight	☐ Ringing in the Ears	
Cardiovascular			
☐ Chest Pain / Discomfort	☐ Cardiovascular Symptom	☐ Heart Murmur	
☐ Swelling lower extremity	☐ Leg Pain with Exercise	☐ Palpitations	
Hematologic/Lymphatic			
☐ Bleeding Problem	☐ Swollen Glands	☐ Lymphoma	
☐ Anemia	☐ Skin Lump - Location		
Respiratory			
☐ Difficulty Breathing	☐ Wheezing	☐ Previous Pulmonary Disease	
☐ Exposure to TB	☐ Cough	☐ Pulmonary Symptoms	
Gastrointestinal			
☐ Nausea	☐ Vomiting	☐ Diarrhea	
☐ Decrease in Appetite	☐ Abdominal Pain	☐ Constipation	
Endocrine			
☐ Often Thirsty	☐ Frequent Urination	☐ Thyroid Disease	
☐ Urinary Symptoms	☐ Prostate Problems	☐ Prior Kidney Disease	
Musculoskeletal			
☐ Musculoskeletal symptoms	☐ Feeling weak	☐ Joint Pain, Arthralgia	
☐ Weakness of limbs	☐ Prior Fracture		
Nervous System			
☐ Ataxia	☐ Speech Difficulties	☐ Headache	
☐ Neuropathy	☐ Confusion/ Disorientation	☐ Fainting	
☐ Convulsions			
Skin			
☐ Rash	☐ Ulcer	☐ Lesions	☐ Sun Sensitivity
☐ Color Change	☐ Slow Healing	☐ Infections	☐ Cracking
☐ Eczema (Pruritus)	☐ Growth	☐ Hair Loss	
Allergic, Immunologic History			
☐ Dermatitis	☐ Rheumatoid Arthritis	☐ Lupus	☐ Collagen Vascular
Psychiatric			
☐ Nervousness	☐ Tension	☐ Depression	

Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMOs and PPOs, managed care organizations, IPAs, Medicare/Medicaid, or other governmental or third party payers, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or payment thereof. Calls maybe recorded for training purposes and quality assurance.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information, to provide you with the Notice of Privacy Practices, and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the finding. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak to the Office Manager to obtain additional information regarding any questions you may have concerning this notice or to receive a printed copy of this notice. This Notice of Privacy Practices is effective as of April 14, 2003.

Family Foot and Ankle Clinic, LLC is also authorized to leave a message on the following if needed:

☐ **HOME PHONE** ☐ **CELL PHONE** ☐ **E-MAIL**

_____ _____

→ **SIGNATURE: Patient, Guardian, or Personal Representative** **Date:**

→ List family/friends that we may discuss your medical/ financial matters with:

Name of Individual: **Relationship (spouse, daughter, son, friend, etc.)**

_____ _____

_____ _____

_____ _____

PATIENT FINANCIAL, OFFICE & PROCEDURE POLICIES

Family Foot and Ankle Clinic is dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

- **Payments** for office services are due at the time of service. We will accept VISA, MasterCard, Discover Card, American Express, Care Credit, HSA, cash or check.

- **Your insurance** policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the account within 90 days from your visit, we will have to look to you for payment. We do not determine payment of a claim- the insurance company does. Please contact your insurance company for any questions on any claims that have been submitted.

- **Time of Service Payments:** We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. **We will bill those plans with which we have an agreement and will only require you to pay the co-pay, co-insurance, and/or deductible at the time of service. Payment is due when services are rendered.** Payment due is based upon primary insurance benefits. If you carry a balance higher than $100.00 you may be asked to pay towards that balance prior to making future appointments.

- **As part of our office policy, we require that your deductible (if not met), co-payment, and/or co-insurance be paid in full at the time of treatment.** You are fully responsible for any amount not paid by insurance. Our office accepts cash, check, Visa, Mastercard and Discover.

- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

- You must inform the office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

- For most services provided in the clinic or outside surgical facility, we will bill your health plan. Any balance due is your responsibility.

- There are certain elective surgical procedures that we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

- **Accounts are subject to an 18% finance charge if bill is not paid within 60 days of receiving your patient statement from Family Foot and Ankle Clinic, LLC.**
  There is a service fee of **$35.00** for all returned checks. Your insurance company does not cover this fee.

PATIENT FINANCIAL, OFFICE & PROCEDURE POLICIES Continued:

- **Cancelled/Broken surgical appointments:** Kindly give **24-hour notice** if you need to cancel an appointment, We understand there are times when an appointment will be missed due to unforeseeable circumstances. However, repeat no shows for office appointments or for time blocked for surgical procedures, there will be a **$35.00** no show fee charged for each no show. **Cancelled/Broken surgical appointments will be charged a $50.00 fee.** Each no show prevents a potential patient from being seen in the office; this is not fair to our patients or to our doctors. A 24-hour notice is requested.

- **Medicare**: Trimming of corns and calluses is considered a routine procedure by **MOST** insurance companies (with the exception of Medicare). You will be required to pay for this service as an out-of-pocket expense. Medicare only allows these services once every 61 days.

- **Disability/FMLA Forms:**
  There will be a charge of $25.00 minimum to fill out Disability/FMLA forms. This amount is subject to change. Payment is due before the completed paperwork can be faxed.

- **X-Rays taken in our office are digital images**: You may obtain a CD of the x-ray images for a charge of $15.00. Please call our office, release of information form filled out requesting images and allow (two) 2 business days for digital images. Once the CD has been created, the $15.00 charge will be applied to your account, even if you fail to pick up the record.

➢ USE OF CELL PHONES IS PROHIBITED

I fully understand and agree to the above stated financial policy for Family Foot and Ankle Clinic, LLC. I also understand by signing this agreement that I am giving my authorization to facilitate payment by third parties for services rendered and to agencies/third parties which may be contracted to facilitate collection of any accounts which are past due. Due to contract language between physician and insurance company, I understand I am financially responsible for all charges deemed as "non-covered benefits" by my insurance company even if the insurance's explanation of benefits state the procedure is a "non-covered benefit" and "patient is not responsible".

_____ _____

→ **Signature of Patient, Parent/Guardian, or POA** **Date:**

Narcotics Policy

Our office policy on the use and prescription of narcotics is as follows:

No new narcotic or refill narcotic prescriptions will be issued after 5:00 PM Monday through Thursday, after 12:00 PM on Friday, or on weekends – **NO EXCEPTIONS**. If you feel that you are going to run out of your prescription, please call us at least one business day prior to needing the refill so your physician may review the request before you run out. Prescriptions will not be filled if you have not been seen within 1 month. Narcotic prescriptions may not be called in to your pharmacy. A physical prescription is required.

Office Visits:

- No narcotics will be prescribed for chronic pain. However, narcotics may be prescribed for acute injuries when they are less than one week old. The narcotic prescription will not exceed 5 days of treatment.
- If you are under the supervision of a pain management physician, we expect you to disclose this information to us on your first visit. Failure to do so would be fraud and would violate your contract with your pain management physician. Further, if you have been receiving narcotics from your primary care physician or any other physician, we expect you to disclose this information.

Post-operative:

- Narcotics will only be prescribed for a period of two to three weeks after a surgical procedure. Under extreme circumstances, a patient may receive narcotic medications for up to three months post-surgery. If the pain continues after this time, a pain management consult will be issued. There are occasional exceptions to this rule, but your physician may need to see you to reevaluate your condition prior to renewing your prescription.
- If you are on chronic narcotics from a pain management physician, you will need to receive your post-operative pain medicine from that physician, unless pre-arranged with us prior to your surgery.

As part of keeping our patients informed, we want to make you aware of the reasons we limit the use of narcotics.

1. Severe postoperative/post injury pain that would require narcotics will usually reduce significantly by 2-3 days after surgery or injury and is usually gone by 10-14 days. Postoperative needs for narcotics longer than this period may signal complications that potentially require a more direct or specific treatment plan instead of covering up the problem. Often, a need for narcotics longer term indicates the patient may be overdoing things and compensating with narcotics. Although you may desire to be active, it is possible to be too active. It is important to listen to your body and respond to the cues it gives. A quicker recovery is more likely with reduced activities so that pain is controllable without narcotics. The goal is to make the best recovery from surgery or injury as possible.
2. After 3-7 days, your brain wants to, and is supposed to manage the pain naturally. This is the best way to manage medium and long-term soreness and mild pain. Narcotics are known to block these normal processes, inhibiting the body's own pain control.
3. Narcotics are proven to be habit forming. Dependency on pain medication can start in as little as 2 weeks after beginning use. We cannot tolerate allowing this to happen.

Narcotics Policy Continued:

The Wisconsin Podiatric Medical Association and the Drug Enforcement Administration track physicians and their prescribing or narcotics. Podiatric surgeons are not expected to prescribe narcotics for long-term use. We agree with this policy set forth by our state. Therefore, if you are receiving narcotics from your previous physician or primary care physician, you will need to continue to see them for prescriptions.

We do not deny that you may have pain. However, it is necessary to be aware of your body's own ability to tolerate pain and the need to rely on this process in a timely manner. We have created this policy to assist in assuring that our patients receive the best possible care and appreciate your assistance in enforcing it.

If you have any questions regarding our office policy on the use of narcotics, feel free to contact us so we can discuss it further. IF you feel you need assistance with long-term (chronic) pain control, we will be happy to guide you to a pain management specialist.

I have read, understand, and agree to the above policy:

→ _____ _____ _____

Print Name: *Sign Name:* *Date:*

PATIENT CREDIT CARD ON FILE AGREEMENT

We have implemented a policy which enables you to maintain your credit card information securely on file with Family Foot and Ankle Clinic, LLC. In providing us with your credit card information, you are giving Family Foot and Ankle Clinic, LLC permission to automatically charge your credit card on file for your co-pay and/or deductible amount (or any other patient(s) you have listed on this form) at time of service. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

As part of our office policy, we require that your deductible (if not met), co-payment, and/or co-insurance be paid in full at the time of treatment. You are fully responsible for any amount not paid by insurance. Our office accepts cash, check, Visa, Mastercard and Discover.

COPAYS: Co-pays are due at time of the office visit.

OUTSTANDING BALANCE: If your insurance provider has paid their portion of your bill (or any other patients(s) you have listed on this form) and there is an outstanding balance owed, you authorize Family Foot and Ankle Clinic, LLC to charge your credit card on file for the full amount due. A copy of the charge will be will be sent by email or mailed to you upon request. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

MULTIPLE USERS: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

I authorized Family Foot and Ankle Clinic, LLC to charge co-pays and outstanding balances on my account to the following credit card:

☐ VISA ☐ MasterCard ☐ American Express ☐ Discover Network ☐ CareCredit ☐ HSA Health Savings Account

Credit Card Holder's Name:_____

Credit Card Number:_____

Expiration Date:_____ Security Code _____
(3 or 4 digit # on back or front of card)

If you wish to leave this credit card on file for other patient(s), **please print names(s)** below:

Patient Full Name: _____ Date of Birth: _____
(Please Print)

Patient Full Name: _____ Date of Birth: _____
(Please Print)

CARD HOLDER SIGNATURE: _____Date of Birth:_____

PRINT NAME: _____

CARD HOLDER ADDRESS: _____ZIP CODE:_____