GREEN FOOT & ANKLE CARE, LLC
PATIENT INFORMATION

Please Use Blue or Black Ink

Patient Legal Name: _____ Nickname: _____
FIRST MIDDLE INITIAL LAST

Primary Phone: (____) _____ Secondary Phone: (____) _____

Address: _____
STREET CITY STATE ZIP

Birth Date: _____/_____/_____ SSN: _____-_____-_____ E-Mail: _____

Sex: Male Female Marital Status: Single Married Widowed Divorced Separated

Race: White Black/African American Other _____ Ethnicity: Hispanic Not Hispanic Primary Language: _____

Employer: _____ Work Phone: (___) _____

Address: _____
STREET CITY STATE ZIP

Occupation: _____

Responsible Party: _____ Relationship: _____
Home Phone: (___) _____ Cell Phone (___) _____ Work Phone (___) _____
Address: _____
STREET CITY STATE ZIP

Birth Date: _____/_____/_____ SSN: _____-_____-_____ Employer: _____

**** If you have a Medical or Financial Power of Attorney, all paperwork must be presented to the office at the time of the appointment. Failure to provide legal documentation may result in the cancellation of the appointment.**

Emergency Contact not living with you: _____ Relationship: _____
Home Phone: (___) _____ Cell Phone (___) _____ Work Phone (___) _____

INSURANCE INFORMATION

PLEASE PRESENT YOUR INSURANCE CARD(S) & DRIVER'S LICENSE TO THE RECEPTIONIST TO COPY

Policy Holder: ☐ Self ☐ Responsible Party (as above)
☐ Other: Complete the following

Primary Insurance: _____
ID #: _____
Group #: _____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber SSN: _____
Subscriber Employer: _____
Subscriber Address: _____
Relationship to Patient: _____

Policy Holder: ☐ Self ☐ Responsible Party (as above)
☐ Other: Complete the following

Secondary Insurance: _____
ID #: _____
Group #: _____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber SSN: _____
Subscriber Employer: _____
Subscriber Address: _____
Relationship to Patient: _____

CONSENT FOR TREATMENT

Must be signed by all patients or guardians prior to being seen by physician

I certify that the information is true and correct to the best of my knowledge. I give my permission to the doctor to examine, photograph, x-ray, administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problems.

_____ _____ _____
Signature of Patient, Parent, Guardian or Personal Representative | Relationship | Date

MEDICAL HISTORY

Please fill out all blanks, use N/A if question does not apply

Patient Legal Name _____ Birth Date _____/_____/_____

Are you pregnant? _____ Shoe Size _____ Weight _____ Height _____

Past Medical History – Please circle those that apply

AIDS/HIV	Chemical Dependency	High Blood Pressure	Shortness of Breath
Anemia	Circulatory Problems	History of Chemotherapy	Stroke
Angina	Diabetes	Kidney Problems	Swelling in Ankle/Foot
Arthritis	Epilepsy/Seizures	Liver Disease	Thyroid Disease
Artificial Heart Valves/Joints	Fainting	Mitral Valve Prolapse	Transfusions of Blood
Asthma	G.E.R.D.	Phlebitis	Tuberculosis
Back Problems	GI Ulcers/Bleeding	Pneumonia	Ulcers
Bleeding Disorder	Gout	Psychiatric Care	Varicose Veins
Blood Clots/DVT	Heartburn/Reflux	Respiratory Disease	Weight Loss
Blood Thinners	Hemophilia	Rheumatic Fever	
Cancer	Hepatitis or Jaundice	Sexually Transmitted Disease	

Any other medical conditions not listed here _____

Surgical History, please list all surgeries _____

_____

Hospitalizations, other than for surgeries _____

_____

Any Major Injuries_____

Allergies - Include allergies to medications, food, etc.

_____

Current Medications - Include both prescription and over the counter medications (Attach list if needed)

_____

_____

Do you take contraceptives? Yes ___ No ___

_____

PODIATRY HISTORY

Chief Complaint(s) _____ Duration of Symptoms_____

Have you had previous treatment for this condition? Yes _____ No _____

Is visit due to an accident? Yes _____ No _____ Have you ever seen a Podiatrist before? Yes _____ No ____

Athletic activities in which you participate (please list and indicate frequency) _____

_____

Family Doctor: _____

Phone: _____ Date Last Seen: _____

Cardiologist: _____

Phone: _____ Date Last Seen: _____

Endocrinologist: _____

Phone: _____ Date Last Seen: _____

Infectious Disease Doctor: _____ Phone: _____

Neurologist: _____ Phone: _____

Rheumatologist: _____ Phone: _____

Vascular Surgeon: _____ Phone: _____

Preferred Pharmacy: _____ Address: _____ Phone _____

Referred By: ☐ Family Doctor ☐ Family Member: _____ ☐ Friend: _____
☐ Internet ☐ Phonebook ☐ Sign/In Area ☐ Other: _____

FINANCIAL POLICY

We will help you receive maximum benefits by filing claims for you. We are committed to providing you with the highest quality medical and surgical care. In return, we ask you be equally committed to being fully responsible for paying our fees. This will help in reducing our billing and administrative burdens, leaving more time for helping you. This dual commitment is the foundation of our relationship. Our goal is to maximize the quality of your care and minimize misunderstandings regarding fees and payment. To ensure quality communication, it is the patient's (and/or guardian's) responsibility to inquire about fees/insurance coverage prior to any service being performed. We accept many different insurance plans, however all plans are not the same and do not cover the same services.

Please note: It is the responsibility of each patient to know his or her contract limitations. Specifically, if your policy requires a written referral prior to your visit. It is the patients responsibility to obtain that referral (or have it sent to our office) prior to making an appointment at Green Foot & Ankle Care, LLC. If there is no referral in place by the time of the appointment, we are either required to reschedule the appointment, or the patient will be responsible to pay for the services provided.

Managed Care Patients/Private Insurance

If you are in a managed care plan (HMO, PPO, IPA) with whom we participate, we abide by our contract with them. We will bill your insurance company; however you are responsible for paying any Co-pays, Co-insurance and Deductibles required by your plan at the time of treatment.

Medicare Patients

We accept assignment for Medicare but that does not mean that all services are covered. Patients are responsible for paying their annual deductible. You are also responsible for any co-insurance, which is usually 20% of the allowed amount for an item or service.

Uninsured Patients

A minimum of $125.00 in the form of cash, check or credit card is due at the time of service. Additional charges may apply.

All Patients

For your convenience, we accept Visa, MasterCard, Discover, American Express, Debit, Cash or Check. There is a $10 service fee for all returned checks.

Separate Billing Notice

Please understand you will receive a statement for services from Green Foot & Ankle Care,LLC and if a procedure is performed you may also receive a separate statement from the lab for pathology testing. You also understand if a procedure is performed at an outpatient facility a separate statement will be received from the facility for the facility services.

DURABLE MEDICAL EQUIPMENT POLICY

It is the policy of this office to help obtain insurance benefits regarding a patient's individual coverage of these items. This is a courtesy, which we are happy to provide; however, Green Foot & Ankle Care, LLC is not responsible for the accuracy of the information received. Information received by phone is not a guarantee of payment and if any doubt exists as to eligibility, it is highly recommended that you check your plan booklet for a detailed outline of your benefits or make a personal phone call to your insurance company. Please note, if these items are denied by insurance due to coverage limitations, the patient hereby accepts responsibility for the cost.

Patient or Authorized Representative's initials represent that you read, understand and accept these policies

Initial _____ **Date** _____

DISCLOSURE AUTHORIZATION

Patient Legal Name _____ DOB _____/_____/_____

May we leave a message at your home or with other residents? Yes No

May we leave a message on your answering machine/voicemail? Yes No

May we send you an e-mail? Yes No

We now offer a way to access your personal health information through a patient web portal. With this web portal, you can view all your appointments, your medical history at Green Foot & Ankle Care, LLC and you have the option to message our office. If you wish to participate please provide your e-mail address below. (The receptionist will give you your User Name and Password upon signing in at your appointment.)

☐ Yes, I am interested, my e-mail address is: _____

☐ No, I do not wish to participate at this time

Whom may we discuss your medical/financial information with?

Name _____ Relationship _____

Home Phone _____ Cell Phone _____

Name_____ Relationship _____

Home Phone_____ Cell Phone _____

Name _____ Relationship _____

Home Phone _____ Cell Phone _____

PRIVACY DISCLOSURE AGREEMENT

Green Foot & Ankle Care, LLC will use and disclose your health information for the following purposes: to treat you, to assist other health care providers in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operation activities, such as quality assessment, licensing, accreditation and training of students. Except, as stated in more detail, in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you have any questions, concerns, or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices available to you.

Green Foot & Ankle Care,LLC is compliant with HIPAA policies and a copy is available upon request at time of appointment. Please indicate the appropriate box and sign and date below:

Would like a copy _____ **Decline a copy** _____

_____	_____	_____
Signature of Patient, Parent, Guardian or Personal Representative	Relationship	Date