

# PREMIER FOOT & ANKLE

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_M\_\_\_F

Social Security #: \_\_\_\_\_ Employed: \_\_\_Y\_\_\_N Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell #: \_\_\_\_\_

Email: \_\_\_\_\_ \*\* Circle which to use for reminder calls.

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Physicians Name: \_\_\_\_\_

Physician Contact Number: \_\_\_\_\_ Date Last Seen: \_\_\_\_\_

## How did you hear about us: (Please circle)

Physician    Internet    Insurance    Plano Profile    Allen Image    Friend    Family  
Frisco Running Company    Living Magazine    Frisco Running Club    Other \_\_\_\_\_

## Insurance Information

Primary Insurance Name: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Policy Holders Date of Birth: \_\_\_\_\_ Patients Relationship to Policy Holder: \_\_\_\_\_

**Married**

**Single**

**Divorced**

**Widowed**

## EXPLANATION OF PAYMENT POLICY & PRIVACY POLICY

I hereby authorize Premier Foot & Ankle to release medical information pertinent to the filing of insurance claims for me. I authorize my insurance carrier to pay benefits directly to Premier Foot & Ankle on any unpaid services filed on my behalf. I understand that I AM RESPONSIBLE for payment to Premier Foot & Ankle for charges for the above patient regardless of my insurance coverage. I also understand that Premier Foot & Ankle is not ultimately responsible for collecting my insurance or negotiating settlements of claims. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have had the opportunity to read and understand the Notice. I also hereby give Premier Foot & Ankle permission to diagnose and administer treatment for my foot and/or ankle condition and authorize any release of information obtained in the course of my treatment. **I allow Premier Foot & Ankle to receive and release my personal and medical information that may be pertaining to my treatment, medical history and also diagnosis.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# PREMIER FOOT & ANKLE

Patients Name: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

Reason for your visit: \_\_\_\_\_ Pain Level: \_\_\_\_\_

Alcohol Intake: \_\_\_\_\_ Caffeine Intake: \_\_\_\_\_

Smoker: \_\_\_\_\_ pack(s)/day X \_\_\_\_\_ years Previous smoker: YES NO; How much/long: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Constitutional: Are you currently experiencing (please circle): Nausea Vomiting Fever Chills Night Sweats

Have you had a Flu shot this season? YES NO Have you had the pneumonia vaccine? YES NO

Medications: List current medications & dosage:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Medical History: If you now have or have ever had any of the following conditions, please circle and be more specific in the blank space below:

Thyroid Problems	Hepatitis _____	Cancer _____	Ear Disorders _____
Multiple Sclerosis	Hearing Loss	Circulation Problems	Eye Disorders _____
Heart Disease _____	ADD/ADHD	Heart Burn/Reflux	Lymphedema
Anxiety	Bipolar Disorder	Back Problems	Alcohol/Drug Dependency
Anemia _____	Currently Pregnant	Depression	High Blood Pressure
Children/Pregnancies	Fibromyalgia	Asthma	High Cholesterol
Gout	Prostate Problems	Breathing Problems	Current Kidney Dialysis
Osteoarthritis	Lupus	Pre Diabetes	Diabetes: Type I or Type II
HIV/AIDS	Osteoporosis/bone density	Kidney Problems _____	# of years _____
Neuropathy	Parkinson's	Alzheimer's/ Dementia	Other _____

Allergies: Yes No If yes, please list: \_\_\_\_\_

Family History: Please circle any medical conditions that run in your family and write which member(s) affected

Diabetes \_\_\_\_\_ Gout \_\_\_\_\_ Heart Disease \_\_\_\_\_ Circulation Problems \_\_\_\_\_ High Blood Pressure \_\_\_\_\_

High Cholesterol \_\_\_\_\_ Other \_\_\_\_\_

Surgeries: List all surgeries you have had. Begin with the most recent. Please give the year.

\_\_\_\_\_  
\_\_\_\_\_

If diabetic, who handles your diabetes? \_\_\_\_\_ Phone #: \_\_\_\_\_

Last A1C? \_\_\_\_\_ Performed by/Date: \_\_\_\_\_

\*\*For those patients 65 years of age or older, do you have a living will or have someone to make decisions on your behalf? YES or NO

## **PREMIER FOOT & ANKLE**

Your understanding of our financial policies is an essential element of your care and treatment. If you have any 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.
- Unless other arrangements have been in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, 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 doctors. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, you will receive a bill.
- 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 an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for services or referrals; 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 insurances changes and authorization/ referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- There are certain elective surgical procedures for which 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 or at the time of your Pre-op appointment.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office.
- Patients who are 90 days past due on their balance will be sent to collections, unless a payment plan has been put into place.
- There is a service fee of \$25.00 for all returned checks. Your insurance company does not cover this fee.
- In fairness to all of our patients, we understand that emergencies occur, but repeated no shows or cancellations with less than 24 hours’ notice will result in a fee of \$25.00. You might be asked to pay before you are seen by the doctor.
- Patients who come to office fifteen minutes later than scheduled appointment might be asked to reschedule.

Signature of Patient/ Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Patient/ Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

**DISCLOSURE OF PHYSICIAN FINANCIAL INTEREST**

This document is to disclose that Dr. Korpinen and/or his associates have a financial interest in the following:

- Texas Health Surgery Center of Craig Ranch
- SurgCenter of Plano, LLC.

The Doctors of Premier Foot & Ankle want you to know that you do have the option to use an alternative health care facility.

Please sign below acknowledging receipt of this disclosure:

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Patients Signature

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Date