ADVANCED
FOOT & ANKLE

176 Falls Ave Ste 200
Twin Falls, ID 83301
208-731-6321

PERSONAL INFORMATION

Today's Date: _____

☐ Mr. ☐ Mrs. ☐ Miss

Last Name	First Name	M.I.	Preferred Name
Birthday:	Home Phone #	Cell Phone #	

Local Address:	City:	State:	Zip:

Social Security #	Sex: M / F	Marital Status: S M W D

Email:	Second Address:
Occupation:	If retired, your former occupation:
Employer:	Business Phone:
Spouse:	Have they been treated here? Yes / No
Are any of your friends, relatives, or associates our patient?	If yes, who?
If under 18y/o, name of parent/guardian:	Relationship to Patient:
Responsible Party's DOB:	Responsible Party's SS#
In case of an emergency, call:	Relationship:
Phone:	Pharmacy:

Whom do we thank for your referral?_____

How did you hear about our practice? _____

If you used the internet to find us what search terms did you use?_____

Office Use: IC _____ SB _____ MA _____

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OTHER PHYSICIANS BEING SEEN

Primary Care Provider:	Date of Last Visit:
Refering Provider:	Date of Last Visit:

MEDICAL HISTORY

How is your general health? ☐ Good ☐ Fair ☐ Poor

Do you now have, or have you ever had any of the following (please check all that apply)

- ○ Anemia
- ○ Asthma
- ○ Atrial fibrillation
- ○ Anxiety
- ○ Bladder infection
- ○ Blood disease/clots
- ○ Cancer:
- ○ Cellulitis
- ○ Chest pain
- ○ Congestive heart failure
- ○ COPD/emphysema
- ○ Coronary artery disease
- ○ Depression
- ○ Diabetes
- ○ Dialysis
- ○ Epilepsy
- ○ Fractures
- ○ Glaucoma
- ○ Gout
- ○ Heart attack
- ○ Heart arrhythmia
- ○ Heart Valve disease
- ○ Hiatal hernia
- ○ High blood pressure
- ○ High cholesterol
- ○ HIV
- ○ Kidney disease
- ○ Kidney stones
- ○ Liver problems
- ○ Numbness in feet/ legs
- ○ Osteoarthritis
- ○ Osteoporosis
- ○ Pancreatitis
- ○ Reynaud's disease
- ○ Rheumatoid arthritis
- ○ Sinus problems
- ○ Sleep apnea
- ○ Stomach ulcer
- ○ Stroke
- ○ Thyroid disorders

Other: _____

SURGICAL HISTORY: Please list any surgeries you have had:

_____

_____

MEDICATIONS: Please list all **current** medications including **dosages**. Or provide a copy/ list of your medications.

_____

_____

_____

_____

_____

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ALLERGIES: Please list any allergies you have to medicines, and your reactions. Include adhesive tapes, latex, foods, etc.

Allergy	**Reaction**

SOCIAL HISTORY:

Do you currently smoke or vape? Y / N	Total years of smoking?		
Former Smoker? Y / N	What year did you quit?		
Drink Alcohol? Y / N	What type?	How often?	How much?
Recreational Drugs? Y / N	What type?		
How often?	How much?		

FAMILY HISTORY: Please list disease or illnesses of your immediate family (parents, grandparents, siblings): _____

_____

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PRIVACY CONSENT

You agree to permit your protected health information to be used and disclosed for purposes of treatment, payment, research, and health care operations. For more details about these uses and disclosures, please see our Privacy Notice.

We reserve the right to change our privacy policies described in the Privacy Notice. You may request a copy of our Privacy Notice at any time.

You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment, research or health care operations. We are not required to agree with this request, but if we do, we are bound by it.

You have the right to revoke your consent in writing. A revocation, however, will not apply to the extent we have taken action in reliance upon the use of disclosure of your information.

I will receive a copy of Advanced Foot % Ankle's Privacy Policy Notice upon request.

Phone Message Consent

I authorize Advanced Foot & Ankle to leave messages concerning my appointment, accounts, and healthcare on my voice mail, with persons answering phone numbers listed on my account, and with persons listed as alternate contacts on my account.

Consent for X-Rays

I consent to the performance of x-rays which the physicians of Advanced Foot & Ankle may consider necessary or advisable. I accept the risk of exposure to x-rays in hopes of obtaining desired beneficial health care results.

Quotation of Insurance Benefits and Coverage

Our office would be happy to contact your insurance company for you if you have questions about your insurance coverage and benefits. However, please note that information concerning insurance coverage and benefits is provided as courtesy, is an estimate only, and is based on information we receive from your insurance company. Actual coverage will be determined by your insurance company when they process your claim for payment. It is ultimately your responsibility to understand your insurance policy, benefits, and coverage. Payment for services denied by your insurance company will be your responsibility.

Patient or Patient Agent signature

Date Signed

Print Name

Witness signature and Title

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CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY

As neither the Patient nor the legally authorized representative of the Patient, the following consents, understandings, and agreements are made on my behalf or on behalf of the Patient in partial consideration of the health care services to be provided to the Patient by ADVANCED FOOT & ANKLE. If a new consent document is signed, the terms of the new document will apply to services received from the date the new document is signed

Consent for Services: On behalf of the Patient, consent is hereby given to ADVANCED FOOT & ANKLE, its medical staff and employees, to provide health care services to the Patient.

Release of Information: The law requires ADVNACED FOOT & ANKLE to make and keep records of your medical treatment; ADVANCED FOOT & ANKLE safeguards those records. Access to medical records is limited to person who are providing, coordinating, evaluating, or improving health care, and to persons who are involved in maintaining medical records, subjects to applicable law. By receiving services at ADVANCED FOOT & ANKLE, you agree to the release of medical record information for the uses specified above and as stated in our Privacy Notice. You also agree to release claims related information to insurance companies other third parties to assist in paying your health care costs. You also have the right to access your medical record. There will be a charge of $1/page for copies of your medical record. I understand that ADVANCED FOOT & ANKLE is given thirty days to process my request for access if my information is maintained on site, sixty days if maintained off site.

Assignment of Benefits: Any and all benefits from insurance companies and other third party payers that are payable to Patient or are paid on behalf of Patient for health care services and related payments for services rendered or provided to Patient are hereby transferred and assigned to ADVANCED FOOT & ANKLE for the exclusive purpose of paying for charges associated with health care services provided to the Patient. It is understood and intended that all insurance companies and other third party payers will benefit directly ADVANCED FOOT & ANKLE; patient shall remit insurance company's payment and Explanation of Benefits to THE FOOT AND ANKLE HEALTH CENTER with in 10 calendar days of receipt of payment.

Financial Responsibility: Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay for all health care services rendered to Patient at ADVANCED FOOT & ANKLE or by physicians or employees for ADVANCED FOOT & ANKLE, including but not limited to any amounts not paid by insurance company or other third party payer. Patient and undersigned, if other than the Patient, remains responsible for all co-payments, deductibles, co-insurance, denied services, and/or non-covered services regardless of the amount paid by insurance or third party payer. It is understood and agreed that charges that are not paid in timely fashion may be placed for collection. If it is further understood and agreed by the Patient and the undersigned that any amounts not paid within 30 days from the date of ADVANCED FOOT & ANKLE bill or statement for payment may accrue interest at the rate of 1 ½% per month (18$% annually), or $10.00 per month, whichever is greater. In the event that any unpaid balance is placed for collection or with an attorney for purposes of collection, I Patient, or undersigned, if other than the Patient, each jointly and severally agree to pay collection costs of 29% plus reasonable attorney's fees in connection with the collection process. A service charge of $20.00 may be collected in connection with any check or other instrument tendered by me but returned unpaid to ADVANCED FOOT & ANKLE.

Missed Appointments: ADVANCED FOOT & ANKLE reserves the right to charge a no-show fee of $25.00 for each missed appointment. Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay any no-show fees assessed for missed appointments.

Referrals & Pre-authorization: It is agreed that the patient will be responsible for obtaining and referral or pre-authorization required by any insurance carrier, including referral from a managed care provide or primary care physician, to ensure proper reimbursement from said insurance carrier.

Medicare/Medicaid patient's certification: I request payment of authorized benefits to ADVANCED FOOT & ANKLE on my behalf for any services furnished me by ADVANCED FOOT & ANKLE, including physician services. I authorize any holder of medical or other information about me to release CHAMPUS/CAMPVA/TRICARE and its agents any information needed to determine these benefits or benefits or any related services.

The undersigned signs this document either as the Patient or as the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction and I understand what I am agreeing to by signing below. I understand that I am entitled to request and obtain a copy of this document.

Patient or Patient Agent signature	Date Signed
Print Name	Witness signature and Title