North Shore Foot & Ankle S.C.

PATIENT REGISTRATION

Today's Date: _____

Patient Name: _____ **Gender** _____
First MI Last

Social Security Number: _____-_____-_____ **Date of Birth**: ___-___-___ **Age:** _____ **Race:**_____

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

Phone ( ) _____ ☐ Cell ☐ Landline **Spoken Language:** _____

For appointment reminders, order notifications, and requests for you to call back …
Is it OK to leave messages: ☐ No ☐ with spouse/partner ☐ with anyone who answers
Is it OK to TEXT you? ☐ YES ☐ NO
Is it OK to EMAIL you? ☐YES, email address_____ ☐ NO

Emergency Contact:_____ Relationship: _____Phone: _____

If patient is a minor (list all that apply) :
Parent or Legal Guardian: _____Relationship: _____
Address: _____ Phone:_____ DOB: _____
Parent or Legal Guardian: _____Relationship: _____
Address: _____ Phone:_____ DOB: _____

Patient's Primary Care Physician: _____

Marital Status: ○ Single ○ Married, Name of Spouse: _____
Employment Status ○ Employed Full time ○ Employed Part time ○ Not Employed

Employer: _____Occupation:_____

How did you hear about our office?
○ Dr. Referral (Name of Doctor: _____ ○ Word of Mouth
○ TV OR Internet ○ Insurance Co ○ Other:_____

Primary Insurance Coverage:_____ Effective Date: _____
IF COVERAGE IS NOT THROUGH THE PATIENT:
Name of Member: _____ Relationship to Patient: _____
Policy Holder's DOB:_____ Policy Holder's SSN:_____ (required)

Secondary Insurance Coverage:_____ Effective Date: _____
IF COVERAGE IS NOT THROUGH THE PATIENT:
Name of Member: _____ Relationship to Patient: _____
Policy Holder's DOB:_____ Policy Holder's SSN:_____ (required)

Is This a Worker's Comp. Case? ○ **No** ○ **Yes** If Yes, Date of Injury:_____
Workers Comp. Carrier:_____

Patient (or Parent/Guardian) Signature _____ **Date** _____

North Shore Foot & Ankle S.C.

PATIENT HEALTH INFORMATION

Patient Name: _____ Date of Birth ___/____/___
First M Last

What bring you into our office today?_____

LIST ALL ALLERGIES_____

MEDICATIONS ○ *No Medications*

Please list all your current prescriptions, including over-the-counter medications and vitamins:

_____

_____

PATIENT and FAMILY'S PAST MEDICAL HISTORY ☐ *NO past personal* ☐ *NO family history*

Check all that apply to the patient and/or to family blood relatives :

	Patient	Mom	Dad	Sis	Bro		Patient	Mom	Dad	Sis	Bro		Patient	Mom	Dad	Sis	Bro
Autoimmune Disorder						Cancer						Malignant Hyperthermia					
AIDS/HIV						Chemical Dependency						MRSA (staph infection)					
Alzheimer's						Chest Pain						Peripheral Neuropathy					
Anemia						Circulatory Problems						Phlebitis					
Migraines						Diabetes						Psychiatric Care					
Anxiety						Epilepsy						Radiation Treatment					
Arthritis						Fainting						Raynaud's Disease					
Rheumatoid Arthritis												Respiratory Disease					
Artificial Heart Valve						Fibromyalgia						Rheumatic Fever					
Artificial Joints						Gout						Reflex Sympathetic Dystrophy					
Asthma						Heart Disease						Shortness of Breath					
Back Problems						Hepatitis						Stroke					
Bleeding Disorders						High Blood Pressure						Thyroid					
Blood Clots						High Cholesterol						Tuberculosis					
Bunion						Liver Disease						Ulcers					
						Low Blood Pressure						Varicose Veins					
						Kidney Disease						Currently Pregnant					

LIST PAST SURGERIES ___ *I have had no surgeries.*

_____

_____

Alcohol Use: Do not drink Less than 3/mo 1- 2 drinks/wk 3-5 drinks/wk 5 or more/wk

Do you smoke or vape? _____ If so, for how many years? _____ How much per day? _____

List your current athletic activities (also indicate frequency) _____

SHOE SIZE _____ HEIGHT _____ WEIGHT _____

PREFERRED PHARMACY _____ _____
Pharmacy Name Location (Street, City)

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and/or ankles.

Patient Signature _____ **Date**_____

North Shore Foot & Ankle S.C.

Financial Terms

INSURANCE

If a patient has health insurance and provides us with the necessary information, we will file a claim for services rendered. If insurance does not cover the services provided at Norh Shore Foot and Ankle S.C. (the Practice), patient is responsible for all charges and will be billed for services rendered and all balances are due in full upon receipt.

Insurance Cards of current coverage must be made available upon request at all appointments. We reserve the right to reschedule appointments when card is not available.
Co-Pays are due at time of service or we reserve the right to reschedule the appointment for another time.
Referrals from a patient's primary care physician may be required prior to being seen by our physicians. Please verify referral requirements with your insurance company to ensure eligibility for coverage.
Pre-Authorization/Pre-certification notification requirements are the responsibility of the patient.

WORKERS COMPENSATION AND DISABILITY

Claims will be filed on the patient's behalf at no charge for the first submission, as long as complete and accurate information is provided to us. If a patient requests that additional claims be filed, a **$5.00** fee will be charged to the patient's account with each submission. **Charges that are denied or disputed become the responsibility of the patient** and will be billed accordingly and due upon receipt.

Physician referrals may be required for these cases and are the responsibility of the patient and/or referring physician**.**

NO INSURANCE COVERAGE

Patients without insurance coverage or those who request that claims not be submitted to insurance, are eligible to receive in-office services or DME at a 20% discount **if charges are paid in full and at the time of service.** If payment in full is not made at the time of service, a **minimum** of 50% of the charges incurred will be due at the time of service. No discount is given on over the counter medical supplies or non-medical purchases.

MINOR PATIENTS

Accompanying parent or guardian of a patient under 18 years of age is financially responsible for services received by minor.

DURABLE MEDICAL EQUIPMENT (DME)

- Durable Medical Equipment (DME), such as custom orthotics or walking boots, may be covered by insurance. Claims will be submitted if insurance information is on file and if patient has not informed us, at time of order, that they will be paying out-of-pocket for charges incurred.
- At least a **50%** (or pre arranged amount) deposit for orthotics is required at time order is placed. If any balance remains after after insurance porcesses claim, the deposit will be applied to this or any other outstanding balance before any refund is returned.
- No refunds or guarantees on any durable medical equipment including, but not limited to, prescription orthotics or walking boots.

TERMS OF PAYMENT

- Co-pays, co-insurance, deductibles, and other charges not covered by insurance are the patient's responsibility.
- Account balances, after insurance processing, are due upon receipt of statement. Failure to do so may result in account being sent to collection agency.
- There will be a $35 fee charged to patient's account for all returned checks.
- **No returns on medical supplies after 30 days and must not be opened.**

COLLECTION AGENCY PLACEMENT POLICY

You are financially responsible for the timely payment of your outstanding bill per our payment policies. You will be responsible for any and all collections agency fees up to 30% of the amount placed with the agency. In the event we seek legal action for collection on your account, you will also be responsible for any and all fees associated with court cost, garnishments, and/or attorney fees.

I have read the Financial Policy and understand and agree to its terms and conditions. I hereby authorize the designated doctor to release any medical information necessary to determine benefits payable for related services and to process the claim. I authorize the Practice to submit charges to my insurance. I assign payment directly to the designated doctor for any medical/surgical procedures performed.

_____

Signature Date

_____

Print Name

NORTH SHORE FOOT & ANKLE S.C.

Patient Consent for Use and Disclosure of Protected Health Information

By signing below, I agree to the following:

I acknowledge that I have received and been given the opportunity to review for North Shore Foot & Ankle S.C. ("NSFA") Notice of Privacy Practices which provides a more complete description of such uses and disclosures. I consent to NSFA to use and disclose my protected health information (PHI) to carry out treatment, payment and healthcare operations, otherwise referred to as TPO.

I understand that a revised Notice of Privacy Practices may be obtained by forwarding a written request to: North Shore Foot & Ankle S.C Compliance Officer at 2005 S Lake Park Rd. Appleton, Wisconsin 54915.

I consent to NSFA calling my home or other alternative locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others**.**

I consent to NSFA mailing to my home or other alternative locations any items that assist the practice in carrying out TPO, such as statements, medical documents and notices.

I consent to NSFA e-mailing me at the address provided any items that assist the practice in carrying out TPO, such as appointment reminders, medical documents and statements.

I authorize NSFA to release my protected health information to the following individuals:
Name _____ Relationship _____
Name _____ Relationship _____

I understand I have the right to request that NSFA restrict how it uses or discloses my PHI to carry out TPO. In some cases the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I understand that I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, NSFA may decline to provide treatment to me.

Signature of Patient or Legal Guardian Date:

Patients Printed Name