Absolute Foot Care Specialists **Podiatric Update Form**

Patient Information: **Today's Date:**_____

Patient First Name_____ MI_____ Last Name_____

S.S.#_____-_____-_____ Date of Birth_____/_____/_____ Age_____ ❒ Male ❒ Female

Home Address:_____

City_____ State_____ Zip_____

❒Home Phone:_____ ❒ Work:_____ ❒Cell:_____

Please check the box of the preferred contact phone number

Email Address_____ Occupation_____

Employer_____ Phone(_____)_____

Primary Language_____ Martial Status: ❒ Single ❒ Married ❒ Widowed

Spouse/Partner Name _____ Spouse DOB____/____/____ Spouse S.S.#_____

Emergency Contact Name_____ relationship_____ phone_____

Minors: Name of all parents/guardians_____

Insurance / Payment Information: Check here if you have **NO** health insurance ❒

My insurance benefits; I am responsible for : **Co-pay** $_____ **Deductible** $_____ **Coinsurance** %_____

Do you need a referral from your PCP? ❒ Yes ❒ No If **yes**, do you have a referral? ❒ Yes ❒ No

Primary Insurance_____ Phone#_____

ID#_____ Group#_____

Policyholder_____ Policyholder Birth date_____/_____/_____

Policyholder SS#_____-_____-_____ Relationship to patient_____

Secondary Insurance_____ Phone#_____

ID#_____ Group#_____

Policyholder_____ Policyholder Birth date_____/_____/_____

Policyholder SS#_____-_____-_____ Relationship to patient_____

Medication Record: (please use an additional sheet of paper if needed for medications) **❒NO MEDICATION TAKEN**

Name of medication / dosage / taken how often? Name of medication / dosage / taken how often?

1)_____ **2)**_____

3)_____ **4)**_____

5)_____ **6)**_____

7)_____ **8)**_____

Allergies to Medication: **❒NO ALLERGIES (NKDA)**

Drug Name / Side Effect Drug Name / Side Effect

1)_____ **2)**_____

3)_____ **4)**_____

5)_____ **6)**_____

Are you Diabetic? ❒ No ❒ Yes, Type 1__ Type 2__ **Last HbA1c**_____% **Average blood sugar**: _____

Medical Conditions (please list ALL): _____

_____

Surgery within the past year:_____

_____

Why are you here today?_____

_____

Check your degree of pain: **Minimal** ❒1 ❒2 ❒3 ❒4 ❒5 ❒6 ❒7 ❒8 ❒9 ❒10 **Severe**

Patients Name:_____ **Date:**_____

Do you smoke? ❒ No ❒ Yes **Alcohol use?** ❒ No ❒ Yes, #_____ per ❒day ❒week ❒ month ❒year
Drug Use? ❒ No ❒ Yes, **Type:** ❒Marijuana ❒Crack/Cocaine ❒Methamphetamines ❒Heroin
❒Other_____ Frequency?_____ Last Used?_____ History of Chemical Dependency? ❒ No ❒ Yes
Activity Level: ❒Inactive ❒Sedentary ❒Moderate ❒Vigorous ❒Extreme

Signature/Consent/Permission for Treatment / Assignment and Release / Receipt of Privacy Practices
I understand that the information provided on all the forms in the Podiatric Registration packet are true and correct to the best of my knowledge. I acknowledge that I have received notice of Privacy Practices and my rights as a patient. I give permission to the doctor to administer and perform any such procedures as may be deemed medically necessary in the diagnosis and/or treatment of my feet, ankles and/or lower legs. I the undersigned, have valid insurance coverage with the insurance companies listed on page one, and assign directly to the doctors of Absolute Foot Care Specialists all insurance benefits, if any, otherwise payable to me for services rendered. I recognize that I am financially obligated for any coinsurance, co-pays, deductibles and/or non-covered/denied services that may be required. I understand that I am financially responsible for all charges whether or not paid by my insurance, and I am responsible for all charges made to my account whether or not an insurance company, attorney or third party payor is involved in payment. I agree to pay all collection expenses including attorney's fees, court costs, filing fees, including charges that may be assessed by any collection agency ranging from 40-50% retained to pursue collection of monies owed by me for services rendered by Absolute Foot Care. I hereby authorize Absolute Foot Care Specialists to release any information necessary to secure the payment of benefits. A photocopy of this authorization is to be considered as a valid as the original until it is revoked by me in writing. I authorize the use of the signature below on this page, on all insurance submissions.

Financial Policy of Absolute Foot Care Specialists

1) Insurance. We participate with most health insurance plans, including Medicare and will bill them on your behalf. Knowledge of your insurance coverage, co-pay, coinsurance and deductible is the **patient's responsibility**. Please contact your insurance company with questions you have regarding your coverage. If you do not have insurance, payment is expected in full at the time of service.

2) Co-payments/Co-insurance/Deductible. All co-pays, coinsurance and deductibles are to be paid at the time of service, unless prior arrangements are made with the office. This is part of your contract with your insurance company. I agree to pay all fees at time of service.

3) Non-Covered services. Please be aware that some services that you receive may not be covered by your insurance. By signing below, you acknowledge that you are financially responsible for the services, even if your insurance denies or deems the services as non-covered or not medically necessary. I agree that I will be financially responsible for any and all services not covered by my insurance.

4) Proof of Insurance. All patients/guardians must complete the patient information form and provide a copy of a valid insurance card and picture identification (or responsible party's picture identification) before being seen by the doctor. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of your claim(s).

5) Referrals: If required by your insurance, obtaining the proper referral form from your Primary Care Physician is your responsibility. Patients without a valid referral will be asked to pay in full at the time of service. I acknowledge I will be responsible for the bill if a referral is not received.

6) Claims Submission. On your behalf, we will submit your claim(s) and assist you in any reasonable way to help get your claim(s) paid. We will submit claims to your secondary insurance one time, if applicable. I am aware that the balance of my claim is my responsibility whether or not your insurance company pays your claim.

7) Patient Responsibility with Insurance. Your insurance company may request you to supply certain information directly to them in order to process your claim(s). It is your responsibility to comply with their request in a timely manner, per your insurance contract, if you do not you will be held financially responsible to pay the claim(s) without contractual adjustments.

8) Patient Information Changes. If your insurance, address, name or phone changes, you are responsible for notifying Absolute Foot Care of this immediately, so we may make the appropriate changes to have your insurance claims processed in a timely manner by your insurance. If we are not notified in a timely manner, you may be held responsible for the balance of the claim(s).

9) Nonpayment and Collection policy. (3) Invoices will be sent for your bill, on a monthly basis. If your account is over 90 days past due and no prior payment arrangement has been made, your account will be turned over to a collection agency for non-payment. I acknowledge and agree that in the event I do not pay for services rendered, Absolute Foot Care may place my account with a collection agency. Per NRS 649.375(2)(b), a collection fee of 50% will be added to the balance in the event the terms are not met and reasonable attorney fees and court costs incurred in collection of my past due account. Any bounced checks will carry a bounced check fee of $35.00. By signing below I acknowledge that you accept the terms of our collection policy and all associated fees.

10) Missed appointments. I acknowledge that I will be charged a fee of $35.00 for any missed appointment that is not cancelled 24 hours in advance. If I cancel an appointment on the day of that appointment, I acknowledge I will still be charged this fee.

11) FMLA / Disability Paperwork. Any paperwork, including but not limited to FMLA and disability, will carry a fee of $10.00 per page and will be processed within 15 business days. Payment for this service is due in advance.

SIGNATURE REQUIRED (Please read carefully. Sign and Date below). This entire form will be VOID if modified by the patient. Any patient who does not

Signature Responsible party:_____ **Date:**_____

Name & Relationship to Patient:_____