Desert Canyon
Foot & Ankle

Personal Information - Please Print

Last Name: _____First Name: _____Initial: _____DOB:_____SS#_____

Address:_____

Home Phone:_____Cell:_____Work:_____Email:_____

Gender: _____Language: _____Marital Status: _____**Ethnicity:** Hispanic/Latino Non-Hispanic/Latino **Race:** White, Asian, American Indian/Alaskan Native, Black/African American, Native Hawaiian/Other Pacific Islander, Declined, Unknown

Occupation: _____Retired: Yes No From:_____

Employer Name: _____Address:_____Phone:_____

Reason for Visit: _____

Date Symptoms began: _____Diabetic: Yes No Date of Last Podiatry Visit: _____Auto Injury: Yes No Work Injury: Yes No

Were you seen at a Hospital/Urgent Care: Yes No Facility: _____

Workers Comp Claim #_____Name of Insurance: _____Phone:_____

Emergency Contact Name: _____Phone#:_____Relationship to Patient: _____

Insurance Information

Primary Insurance: _____Policy #:_____Group/Network: _____

Claims/Billing Address: _____Phone:_____

Policy Holder Name: _____DOB:_____Relationship to Patient: _____

Secondary Insurance: _____Policy #:_____Group/Network_:_____

Policy Holder Name: _____DOB:_____Relationship to Patient: _____

Financial Responsible Party Information

Responsible Party Name: _____DOB:_____SS#_____Relationship to Patient:_____

Release of Benefits and Information: I understand that Insurance companies do not pay for all services and/or medical equipment dispensed and agreed upon by me and my physician. I authorize direct payment of all benefits to Desert Canyon Foot & Ankle. I further acknowledge and understand that I am responsible for payment of all services rendered within a reasonable time. I agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I will notify you of any changes in my health status or the above information. Any portion not paid by the insurance, I agree to make payment arrangements for prompt payment. In the event my account is turned over for collections, I understand that I will be responsible for all collection costs.

Patient/Responsible Party Signature: _____Date:_____

13065 W McDowell Rd., Suite C101, Avondale, Arizona 85392 Phone: 623-547-2800 Fax: 623-547-3083

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Current Medication

Name of Medication: **Dosage:**

1.	
2.	
3.	
4.	
5.	

Please circle that which applies either A or B

A. I do not take any medications.

B. I have a prepared list of my current medications which I am providing at this time.
I will keep you informed of any changes in my medication.

Medical History

Please circle only those that apply to you. Indicate if they are **Current** or **Past** issues

Anemia C / P	**Arthritis C / P**	**Asthma C / P**	**Bladder/Urinary C / P**	**Bleeding Disorder C/P**
Broken Bones C / P	**Chest Pain C / P**	**Colitis C / P**	**COPD C / P**	**Depression C / P**
Diabetes Type 1	**Diabetes Type 2 C / P**	**Emphysema C / P**	**Epilepsy C / P**	**Fibromyalgia C / P**
Headaches	**Hearing Impaired**	**Heart Disease C / P**	**Hernia C / P**	**HIV-AIDS C / P**
Hypertension C / P	**Irritable Bowel C / P**	**Kidney Disease C / P**	**Lupus C / P**	**Prostate C / P**
Seizures	**Skin Disorder C / P**	**Sleep Disorder C / P**	**Stomach Ulcer C / P**	**Stroke**
TB C / P	**Thyroid Disease C / P**	**Valley Fever C / P**	**Vision Impairment**	**Weight Loss/Gain**

Please specify Types and Dates for the following:

Birth Defect: _____Cancer: _____Heart Attack: _____Hepatitis:_____

Current Height: _____Weight:_____

Allergies

Please list any food/pet allergies:_____

Please list any medication/drug allergies: _____

No known food/pet allergy. **No known medication/drug allergy.**

Patient/Guardian Signature: _____Date:_____

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Surgical History

Please List Surgeries and year performed: _____

_____

Circle if this applies: **I have never had a surgical procedure**

Family Medical History Please check off those that apply

Medical Condition	Mother	Father	Grandparent	Sibling	Child
Diabetes					
Heart Attack					
Hypertension					
Cancer Specify Type:					
Other:					

Social History Please circle that which applies.

Alcohol Use: Frequent Social Never Previous History of Alcohol Use/Treatment_____

Tobacco Use: Smoking Current Amount: _____ Former Smoker Past Amount_____

Type: Cigarettes Cigars Other: _____**Never Smoked**

Caffeine Use: Frequent Social Never Explain: _____

Preferred Pharmacy Information

Pharmacy Name: _____Phone #_____Fax#_____

Address: _____

Primary Care Physician: _____Phone #:_____Referred By:_____

Advanced Directives

Do you have a Living Will? _____Copy provided? _____Are you an organ donor? _____Card provided?_____

Do you have a durable power of attorney for healthcare? _____Current copy provided_____

Patient/Guardian Signature:_____Date:_____

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Patient Financial Responsibility and Office Procedures

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance guidelines, whenever possible. With your cooperation you should be able to receive all the insurance benefits you are entitled to, and we will be able to focus our efforts to provide you with excellent medical care.

Insurance: We are contracted with numerous managed-care insurance programs. We make every effort to verify coverage and bill the insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan. It is the responsibility of each patient to notify our practice of any changes to insurance plan, name, address, or phone number. It is the responsibility of the patient to know the details of their insurance plan in addition to any lapses in insurance coverage. Any charges that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. If a patient does not inform us of special provisions that may be required by their plan and we provide patient/doctor agreed medically-necessary services, such as custom orthotics, nail procedures etc. that are not covered by the plan we may bill the patient directly.

Co-Pays and Deductibles: The co-pays and deductibles are determined by your insurance carrier. We **cannot** waive them. It is the patients' responsibility to know their co-pay, co-insurance and deductible amounts prior to initiating services with our doctors. We are obligated by contract to collect co-pays before treatment is rendered they **cannot** be billed. We verify with insurance companies eligibility and co-pay amounts for each and every patient. Insurance companies always follow all verifications with "this is not a guarantee".

Cancellation and Rescheduling: To confirm/remind patients of their appointments, we will attempt to contact patients via an electronic service. It is the patients' responsibility to remember the appointment they scheduled. We ask that we be notified at least 24 hours in advance. Our message machine is available 24/7 and we do accept messages as notification. We do understand that emergencies occur, please just call. Any appointment that is not cancelled or rescheduled within the timely manner or numerous cancellations/rescheduling will be subject to a $50.00 fee.

No Show for Scheduled Appointments: We reserve the right to bill patients a $50.00 "No Show" fee for any appointment broken without prior notification.

Billing: Billing questions as of May 1, 2014 will be addressed here in our office. Patients that have balances due will be asked to pay prior to or at the next scheduled appointments. All major credit cards are accepted and payment schedules may be set up. Returned checks will incur a $50.00 fee.

Check-in/Appointment Times: We ask that our patients check in 15 minutes prior to their scheduled appointment time. Often new/update paper work requirements pop up that we will need established patients to complete to set up paper work, collect co-pays etc. prior to getting patients back into the clinic. We make every effort to do this in a timely manner. We apologize for any long wait times our patients' might experience. We are very aware that our patients' time is valuable. We promise to give each and every patient as much time and attention as needed to help with medical needs.

FMLA/Disability, etc. Forms: Must be hand carried by the patient to an office visit to be filled out with the doctor.

I acknowledge that I have read and understand the Financial Responsibilities and Office Procedures of Desert Canyon Foot and Ankle.

Please Print Patient Name/Responsible Party: _____

Signature: _____Date:_____

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QUESTIONS, CONCERNS OR COMPLAINTS

If you have any questions or want more information about this Notice or how to exercise your privacy rights, please contact our office. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services (HHS). To file a complaint with HHS, you may contact the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F HHH Bldg., Washington DC 20201 (OCR Complaint@hhs.gov). **We will not retaliate against you for filing a complaint.**

Signature below is acknowledgment that you had the opportunity to read and understand the previous two pages of the HIPAA Notice of Privacy Practices:

Patient Printed Name: _____Date of Birth (DOB):_____

Patient/Guardian Signature: _____Date:_____

RELEASE OF INFORMATION:

I, _____ here by authorized Desert Canyon Foot & Ankle to release or discuss any and all information

Pertaining to myself or my medical records with the following people:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I authorize Desert Canyon Foot and Ankle to contact me as follows:

Home phone: _____Work phone: _____Cell phone: _____

May we leave a message on machine? Please circle: **YES** **NO**

Patient/Guardian Signature: _____Date:_____

Witness: _____Date:_____