Advanced Foot and Ankle Surgeons, Inc.

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment.

- As our patient, you are responsible for all authorizations and referrals needed prior to seeking treatment with this practice.
- *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 doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the copay, co-insurance, or deductible at the time of service.
- Unless other arrangements have been made in advance and approved by management, or your health insurance carrier, ***payment and co payments for office services are due at the time of service***. We accept VISA, MasterCard, Discover, or check. For cash payment , we do not have currency in the office to make change
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all the charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines services 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 some specialized services or referrals; however, you remain responsible for charges to any services rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You ***must*** inform the office of all insurance changes and authorization or referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- 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 this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- **There is a $25.00 NO SHOW FEE for missed appointments. Your insurance company does not cover this. After 2 NO SHOWS, a deposit of $50.00 is required to schedule any subsequent visits. The deposit will be refunded to you by check via mail less any outstanding patient balance if you show for your appointment. If you fail to show for the appointment, the $50.00 will not be refunded. Your insurance company does not cover this.**

Assignment of Benefits

I, the undersigned, certify that I or my dependent have insurance coverage with
(print insurance policy name here) _____and assign directly to **Advanced Foot and Ankle Surgeons, Inc.** all insurance benefits, payable to be for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION TO MY INSURANCE CARRIER OR PHYSICIAN to provide continuity of care. I authorize the use of my signature on all insurance submissions. By my signature I acknowledge review of this policy and hereby agree to its terms.

Print Name:_____

Signature of Patient/Responsible Party:_____Date _____

Medicare Assignment of Benefits

I assign Medicare payments directly to **Advanced Foot and Ankle Surgeons, Inc.** I authorize the release of medical information to Medicare in the event they request medical records for the processing of a claim. I authorize the use of my signature on Medicare claims submissions. By my signature I acknowledge review of this policy and hereby agree to its terms.

Print Name:_____

Signature of Patient/Responsible Party:_____ Date_____

The Privacy Rights Notice

I, (print name)_____

_____ Have accepted a copy of the Privacy Rights Notice

_____ Have declined a copy of the Privacy Rights Notice

< please Initial > _____

Advanced Foot and Ankle Surgeons, Inc.

Date :_____

Appointment with:

☐ **Dr. Douglas Pacaccio**

☐ **Dr. Thomas Nordquist**

PLEASE COMPLETE EVERY SECTION - DO NOT LEAVE ANYTHING BLANK

Patient Name:_____

Address: _____

City_____State:_____Zip:_____

Date of Birth_____/____/_____ Age _____

I, _____give consent to Advanced Foot and Ankle Surgeons, Inc. to TEXT and EMAIL electronic appointment reminders.

Preferred Phone:_____ Alternate number _____

Email:_____

Preferred Language:_____

Ethnicity: Non-Hispanic ____ Hispanic ____ Other_____

Race: American Indian/Alaska Native___ Asian ___ Black/African American___ Hispanic/Latino__ White/Caucasian___ Pacific Islander/Native Hawaiian___

Employment

☐ Employed Employer name _____ Occupation_____

☐ Unemployed

☐ Retired

☐ Student ☐ Child

Emergency Contact

Name:_____ Relationship to patient:_____

Phone Number:_____

List name(s) of person(s) you give **Advanced Foot and Ankle Surgeons, Inc.** permission to communicate with regarding your medical or financial information.

Name(s):_____ Relationship to patient _____

Do you have a legal guardian or power of attorney? Yes No If yes,

Name: _____ Relationship:_____ Phone:_____

Advanced Foot and Ankle Surgeons, Inc.

INSURANCE INFORMATION

Do you have more than one insurance? **Yes** **No**

Primary insurance- _____ ID # _____

Secondary insurance- _____ ID # _____

Who is the insurance policyholder/ subscriber ? **Self** **Spouse** **Other** _____

Do you know if you have a **Copay ?** **Yes** **No** If yes, amount $_____

Deductible amount $_____ Remaining balance _____

Out of pocket amount $_____ Remaining balance_____

If you are ***not*** the policyholder/ Subscriber please provide the following information:

Policyholder / Subscriber name: _____

Policyholder/ Subscriber Address: _____

Policyholder /Subscriber Date of Birth: _____

Are you being seen today due to a work related injury ? YES NO

If yes, please provide:

Workers Compensation Company name _____

Contact person _____Phone _____

Case/ claim number _____

Date of injury:_____ < Ask receptionist for additional paperwork >

Pharmacy

Name:_____ City/location: _____

Phone: _____

Primary Care Doctor

Dr._____ **Phone**:_____

(please provide first and last name of primary doctor)

Date Last Seen by Primary Care Doctor: Month_____ Day_____ Year_____

***** Exact date of your last appointment is required *****

Advanced Foot and Ankle Surgeons, Inc.

ALLERGIES (List allergy, your reaction and onset date if known)

- ❑ I have **no known** allergies to medications
- ❑ I am ***unsure*** if I have allergies to medications

- ❑ Penicillin:_____
- ❑ Sulfa:_____
- ❑ Iodine/Shellfish:_____
- ❑ Codeine:_____
- ❑ Novocain/Local Anesthesia:_____
- ❑ Latex:_____
- ❑ Adhesive Tape:_____
- ❑ Other_____

_____

MEDICATIONS

- ❑ I am not taking any medications
- ❑ I have provided a list of my medications

Name:	Dosage	How Often

I_____ give consent to Advanced Foot and Ankle Surgeons, Inc. to electronically update my medications from an electronic database. Please initial _____

Advanced Foot and Ankle Surgeons, Inc.

Medical History / Family History

Height _____ Weight _____ Shoe size _____

******* Use the Key symbols in the chart below to indicate if you or any family members have these conditions *******

Key↓		**Key↓**	
X	Self	**PGF**	Paternal Grandfather
M	Mother	**PGM**	Paternal Grandmother
F	Father	**MGF**	Maternal Grandfather
B	Brother	**MGM**	Maternal Grandmother
S	Sister	**C**	Child

Acid Reflux_____

Anemia_____

Arthritis_____

Asthma_____

Back Problems_____

Blood Clots_____

Cancer_____

Diabetes_____

Foot Pain_____

Gout_____

Heart Attack_____

Heart Disease/Failure_____

Hepatitis_____

Other _____

HIV+/AIDS_____

High Blood Pressure_____

Kidney Disease_____

Liver Disease_____

Neuropathy_____

Open Sores_____

Pneumonia_____

Skin Disorder_____

Stomach Ulcers_____

Stroke_____

Thyroid Disease_____

Numbness/Tingling in Feet_____

Autoimmune Disease _____

Advanced Foot and Ankle Surgeons, Inc.

DIABETICS

- ❑ I am not diabetic
- ❑ I have (circle) Type 1 Diabetes Type 2 Diabetes

Who is the doctor managing your diabetes?_____

Are you taking insulin?

- ❑ Yes
- ❑ No

How many years have you been diabetic?_____

Last hemoglobin A1C: _____ Do you monitor your blood levels daily? Yes No

Highest blood sugar level in past month:_____

Lowest blood level in the past month _____

Have you ever had a foot/leg ulcer, diabetic wound ?

- ❑ Yes If yes, where?_____
- ❑ No

How long did it take to heal ? _____

Do you have an ulcer now?

- ❑ Yes If yes, describe location, duration, and treatment:_____
- ❑ No

Have you ever been told you have poor circulation in your feet?

- ❑ Yes If yes, describe: _____
- ❑ No

Have you ever been told you have poor sensation in your feet?

- ❑ Yes If yes, describe:_____
- ❑ No

Have you been prescribed diabetic shoes ? Custom Orthotic shoe inserts?

- ❑ Yes If yes, when & where did you get your last pair? _____
- ❑ No

Advanced Foot and Ankle Surgeons, Inc.

SURGICAL HISTORY

Date: **Type:** **Surgeon:** **Location:**

_____

_____

_____

_____

_____

_____

_____

☐ No surgical history

SOCIAL HISTORY

Use of Alcohol:

- ☐ None
- ☐ Beer
- ☐ Wine
- ☐ Hard Liquor

How much and how often?_____

Use of Tobacco:

- ❑ Never used tobacco
- ❑ Cigarettes
- ❑ Cigars
- ❑ Pipe
- ❑ Chewing/Dipping Tobacco
- ❑ Vape
- ❑ CBD/Marijuana
- ❑ Daily Usage:_____

If you are a former tobacco user, when did you stop ? _____

How long did you use tobacco for ?_____

Advanced Foot and Ankle Surgeons, Inc.

What foot or ankle concerns bring you to the office today?

Problem #1:_____

_____

Location:_____ When did you first experience this problem?_____

What treatment have you had?_____

Problem #2:_____

_____

Location:_____ When did you first experience this problem?_____

What treatment have you had?_____

Problem #3:_____

_____

Location:_____ When did you first experience this problem?_____

What treatment have you had?_____

Were any of these problems caused by an injury?

- ❑ Yes If yes, describe: _____
  Date of injury: _____
- ❑ No

Patient Signature: _____Date: _____

Parent / Guardian signature _____

Relationship to Patient if applicable:_____

If under 18 years of age:

Parents/guardian name _____ Phone _____

Address: _____City:_____State/ Zip _____

How did you hear about our office?

- ❑ Friend > Name _____
- ❑ Internet
- ❑ Family member > Name _____
- ❑ Doctor Referral _____
- ❑ Other _____

Thank you for choosing Advanced Foot and Ankle Surgeons,Inc. for your foot and ankle care.

We take pride in providing exceptional care for all our patients.

Dr. Douglas Pacaccio, DPM FACFAS **Dr. Thomas Nordquist, DPM**