

WELCOME TO OUR OFFICE

Name _____ DOB ____/____/____ Age _____

Address _____ City _____ Zip _____

SSN _____ - _____ - _____ Email _____

Home (____) ____ - _____ Work (____) ____ - _____ Cell (____) ____ - _____

Is there a number we should not call? If yes, please list _____

What number(s) can we leave messages at (please circle)? HOME WORK CELL

EMPLOYER INFORMATION

Occupation _____ Employer _____

Employer Address: _____

City _____ State _____ Zip _____ Phone (____) ____ - _____

SPOUSE CONTACT INFORMATION

Name _____ DOB ____/____/____ SSN _____ - _____ - _____

Occupation _____ Employer _____

Employer Address _____

City _____ State _____ Zip _____ Phone (____) ____ - _____

May we speak to your spouse on your behalf (please circle)? YES NO

Anyone else you authorize to receive information on your behalf? _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____

Address _____ City _____ Zip _____

Home (____) ____ - _____ Work (____) ____ - _____ Cell (____) ____ - _____

NEAREST RELATIVE/FRIEND NOT LIVING WITH YOU

Name _____ (____) ____ - _____

MEDICAL INFORMATION

Name of Primary Care Physician _____ Phone _____

Address _____ City _____ Zip _____

How did you hear about us? (Referral from Doctor, Friend, etc) _____

What is your Foot/Ankle Problem? _____

Previous Foot Care: YES NO Doctor's Name: _____ Date _____

Height _____ Weight _____ Shoe Size _____ Width _____

Medical History: Have you been diagnosed with any of the following? (Please Circle)

- | | | | |
|-------------------|---------------|---------------------|--------------------------|
| AIDS or HIV | Diabetes | Hepatitis | Stroke |
| Arthritis | Epilepsy | High Blood Pressure | Tuberculosis |
| Asthma | Emphysema | Lupus | Thyroid Disease |
| Bleeding disorder | Gout | Multiple Sclerosis | Ulcer/GERD (acid reflux) |
| Cancer | Heart Disease | Kidney Disease | OTHER: _____ |

Current Medications: (Please list all) _____

Do you have any Drug or Food Allergies? Yes No If yes, please list _____

Please list any previous Surgery or Hospitalizations: _____

Have you had a physical exam within the last 2 years? (Please circle one): YES NO

If yes, name of physician _____

Other (Any other information regarding your health that you feel is important to note):

INSURANCE INFORMATION

Primary _____ Policy # _____ Group # _____

Subscriber _____ SSN _____ - _____ - _____ Insured DOB ____/____/____

Secondary _____ Policy # _____ Group # _____

Subscriber _____ SSN _____ - _____ - _____ Insured DOB ____/____/____

PATIENT FINANCIAL OBLIGATIONS

Financial Responsibilities:

- A. You will need to pay your deductible, co-pay, and any outstanding account balance at the time of service.
- B. Bring your current insurance information to each visit. Failure to provide complete and accurate insurance information may result in patient responsibility for the entire bill. **It is your responsibility to understand your insurance benefits.**
- C. In the event that your health plan considers the service to be a "non-covered" benefit, you will be responsible for the charges.
- D. You should understand that your failure to meet your financial obligations to Bailey Foot & Ankle Specialists, PC may result in additional actions such as written correspondence, collection activities, reporting to outside credit bureaus, and termination of your patient relationship with Bailey Foot & Ankle Specialists, PC.

Payment options (co-pays, deductibles, balance after insurance or self-pay): Payment is expected on the day that treatment is rendered unless prior arrangements have been made. You can pay by cash, check, or credit card. Alternative payment plans may be available for those patients who qualify (when made prior to your appointment). You may inquire about this with the Bailey Foot & Ankle Specialists, PC financial representative at our office.

Patient Appointments: We ask that you arrive 15 minutes before your scheduled appointment to register and complete paperwork so that your arrival time does not impact our ability to stay on schedule. We ask that you please call the office promptly if you expect to be a late arrival, are unable to keep an appointment, or need to reschedule an appointment. If you do not cancel 24 hours prior to an appointment, you will be charged \$25.00.

Minors: The parent(s) or guardian(s) accompanying a minor are responsible for payment. Minors must be accompanied by a parent or legal guardian to be treated. Any exception requires a signed "Authorization" to provide treatment. Please ask our receptionist for this form.

Monthly Statement: If you have a balance on your account you will be billed promptly. The total due from you will be summarized at the bottom of the statement. Unless we approve other arrangements in writing, the balance on your statement is due upon receipt. You will receive two statements as a courtesy. After a third statement is sent out any balances not paid will be assessed a monthly late charge of \$10.00. Your late account will be turned over to our collection agency between 90-120 days if payment arrangements have not been made and will negatively impact your credit. You will be responsible for any costs including attorney fees, late fees, and collection fees. All returned checks will be charged a \$30.00 administrative fee and your account will be placed on a cash only basis.

Authorization: I do hereby grant permission to Bailey Foot & Ankle Specialists, PC to administer treatment upon myself or child, as may be deemed medically necessary. I hereby authorize release to a third party payer (such as an insurance company or governmental agency) any medical records and/or condition concerning diagnosis and treatment in connection with a claim for payment for such a treatment and/or diagnosis. I permit a copy of this authorization to be valid as the original. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third party payer within a reasonable period of time, not to exceed 60 days.

I have read the above patient obligations and I agree to follow this policy.

Signature

Relationship

Date