WELCOME TO OUR OFFICE

PLEASE COMPLETE ENTIRELY. THANK YOU.

Name_____ DOB____/____/____ Age_____

Address _____ City _____ Zip Code _____

SSN # _____-_____-_____ Email _____

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

Anyone you authorize to receive information on your behalf? (If patient is a minor, please list parents)

1. _____ Relationship: _____
2. _____ Relationship:_____

Are there any court orders regarding guardianship or custody, if child? YES NO

STUDENT OR EMPLOYER INFORMATION: ____ Full-time Student ____ Part-time Student

Occupation_____ Employer _____

Employer Address _____

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

EMERGENCY CONTACT INFORMATION/PARENT OR SPOUSE INFORMATION

Name _____ DOB ____/____/____

Address _____ City _____ Zip Code _____

Social Security # _____ Employer _____

Employer Address _____

City _____ State_____ Zip Code _____ Phone (____) _____-_____

May we speak to the person listed above on your behalf? YES NO

SECONDARY CONTACT INFORMATION (Please list if different than above information)

Name _____ Relationship _____

Address _____ City _____ Zip Code _____

Home (_____) _____-_____ Work (_____) _____-_____Cell (_____) _____-_____

NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU

Name _____Phone (_____) _____-_____

INSURANCE INFORMATION Do you have Secondary Insurance? YES NO (Please Circle)

Primary Insurance _____ Policy # _____Group #_____

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

MEDICAL INFORMATION

What is your foot or ankle problem? _____

Previous Foot Care? YES NO If yes, doctor's name and date: _____

Height _____ Weight _____ Shoe Size and Width _____

Ethnicity (Please circle one): Hispanic Non-Hispanic Race: _____

Primary Language: _____

Primary Care Physician _____ Phone (___) ___-____

Address _____ City _____ Zip Code _____

Have you had physical exam within the last 2 years? YES NO

If yes, name of physician (if not primary care physician) _____

Pharmacy Name _____ Phone # (___) ___-____

Address _____ City _____ Zip Code _____

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: _____

Smoking status:

____ Current tobacco user (___ packs per day) ____ Not a current tobacco user ____ Non-Smoker

Current Medications (Please List All): _____

_____

_____

Do you have any allergies to food or medications? YES NO

If yes, please list: _____

Please list any previous surgeries or hospitalizations: _____

_____

Family History (please include grandparents, parents and siblings and age diagnosed): _____

_____

_____

How did you hear about us? (Doctor Referral, Friend, Family Member, etc.) _____

COMMUNICATIONS CONSENT:

You expressly consent to be contacted by Bailey Foot and Ankle Specialists or anyone calling on our behalf, for any and all purposes, at any telephone number, or physical or email address you provide or which you may be reached, including wireless telephone numbers. You agree that Bailey Foot and Ankle Specialists may contact you in anyway, including calls or prerecorded or artificial voice or text messages delivered by an automatic telephone dialing system, or email messages delivered by an automatic emailing system.
You expressly acknowledge that this consent cannot be revoked without prior written agreement and acceptance by us.
You agree to promptly notify us at any time your contact information changes.

FINANCIAL OBLIGATION

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 and Ankle Specialists, PC may results in additional actions such as written correspondence, collection activities, reporting to outside credit bureaus, and termination of your patient relationship with Bailey Foot and 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 and 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 your 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.

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 and 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

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

_____ _____ _____

Signature Relationship Date

PATIENT ACKNOWLEDGEMENT HIPAA

I have been presented with a copy of Bailey Foot and Ankle Specialists, PC Notice of Health Information Practices detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information.

_____

_____

I hereby acknowledge receipt of the Notice of Privacy Practices for Bailey Foot and Ankle Specialists, PC. I acknowledge understanding and agree to its terms.

Patient Name (Print): _____

Patient/Parent Signature: _____

Date: _____