

Foot & Ankle Associates of Florida
Medicine & Surgery of the Foot & Ankle

PLEASE PRINT LEGIBLY

Patient's First Name/Middle Int.		Last Name		Sex	Marital Status	Date
Residential Address		City		State		Zip Code
Mailing Address (if different from above)		City		State		Zip Code
Date of Birth	Age	Patient's Social Security Number		Emergency Contact Person and Phone Number		

**Please check below your preferred method of communication from our office in priority order.
 (1st, 2nd, 3rd) ___ Home Phone ___ Cell Phone ___ Email ___ Work Phone**

Home Phone	Cell Phone	*Email Address	<u>Employer</u>
How did you hear about us?			Work Phone Number
*Guarantor's Name (if patient is a minor)	Guarantor's SSN	Guarantor Relationship to Patient?	

INSURANCE INFORMATION

Primary Insurance Name	Secondary Insurance Name (if applicable)
Name of Primary Subscriber	Name of Primary Subscriber
Subscriber's Birth Date	Subscriber's Birth Date

MEDICAL INFORMATION

List any medical conditions you have (allergies, impairments, etc.)

List any medications you are currently taking (include birth control if applicable)

***Pharmacy Name AND Phone Number (or Address)**

Name of Primary Care Physician	Phone Number	If your injury was due to an accident, was it work-related or auto-related? Yes or No
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Reason for your visit today

I hereby give *Foot and Ankle Associates of Florida* permission to examine and treat me. I also authorize the release of any medical information necessary to process my claims. I hereby request payment of any insurance or 3rd party benefits that I am entitled to, be made directly to *Foot and Ankle Associates of Florida* for any services rendered to me during the course of my treatment.

Patient's (or Guardian's) Signature _____ Date _____

Visit our Doctor Store for all your foot care needs www.floridafootdocs.com

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Request for confidential communication of protected health information.

I, _____,
Printed Name of Patient

hereby request and authorize that confidential communication of protected health information be disclosed to the following individual(s):

Name	Relationship
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Telephone Number

Name	Relationship
------	--------------

Telephone Number

Name	Relationship
------	--------------

Telephone Number

Name	Relationship
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Telephone Number

Patient's Signature	Date
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Foot & Ankle Associates of Florida

Medicine & Surgery of the Foot & Ankle

Consent to use and disclosure of protected health information

Use and disclosure of your protected health information:

Your protected health information will be used by *Foot & Ankle Associates of Florida* or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of privacy practices:

You should review the *Notice of Privacy Practices* (available upon request) for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent form.

Requesting a restriction on the use or disclosure of your information:

You may request a restriction on the use or disclosure of your protected health information.

Foot & Ankle Associates of Florida may or may not agree to restrict the use or disclosure of your protected health information.

If *Foot & Ankle Associates of Florida* agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of consent:

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of rights to change privacy practice:

Foot & Ankle Associates of Florida reserves the right to modify the privacy practices outlined in this notice.

Signature:

I have reviewed this consent form and give my permission to *Foot & Ankle Associates of Florida* to use and disclose my health information in accordance with it.

Printed Name of Patient

Patient's Signature

Foot & Ankle Associates of Florida
Medicine & Surgery of the Foot & Ankle
Financial Policy

Thank you for choosing *Foot & Ankle Associates of Florida*. We are committed to providing you with the highest quality podiatric care. If you have health insurance, we would like to help you receive your maximum covered benefits. The following information is provided to help understand this process and alleviate any misunderstandings that might occur concerning payment for professional services rendered.

- We must have accurate information from you in order to process your claim correctly.
- Some services may not be covered by your insurance company as there are many different plans available and not all plans cover all services. It is important that you become familiar with your plan and the coverage available to you.
- We believe that the choice for medical treatment should be yours. Should you choose to receive treatment at one of our offices for any service or product not covered by your insurance company, you agree to be responsible for the payment of these charges.
- You are responsible for any deductible, co-insurance and/or co-payment as stated in your plan. These payments are due at the time of service.
- Your insurance plan is a contract between you and your insurance company. We file claims to your insurance company as a courtesy to you.
- In most cases, we will accept assignment of insurance benefits. What we charge is usual and customary for our area. You are responsible for full payment regardless of any insurance company's arbitrary determination of usual and customary rates. Estimated deductible and co-payments are due at the time of service.
- By law, your insurance carrier must remit payment or deny your claim within 30 days of initial notice of claim. We may need you to assist us in contacting your insurance carrier to resolve any insurance problems.
- Should your insurance company determine a service as "non-covered", you will be held responsible for all unpaid balances.
- We accept Cash, Checks, Traveler's Checks, Visa, MasterCard, Discover, and American Express as forms of payment.
- The fee to copy medical records is: \$1.00 per photocopied page, \$10.00 per x-ray film duplication.

We understand that temporary financial problems may affect the timely payment of your account. If such problems arise, contact our billing office (321-207-2839) for assistance in the management of your account.

I have read and understand the financial policy of *Foot & Ankle Associates of Florida* and agree to all terms and conditions as described in it.

Printed Name of Patient

Patient's Signature

Date