PATIENT INFORMATION

Name _____ Date of Birth ____/____/_____ Age ____
LAST FIRST MI

Address _____ City _____ State _____ Zip _____

SS # _____-_____-_____ Spouse, Parent or Guardian's Name _____

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

Employer _____ Employer Phone (____)_____-_____

Please Check the Appropriate Boxes: ☐ Single ☐ Married ☐ Widowed ☐ Other ☐ Male ☐ Female

Preferred Language _____ Race _____ Hispanic ☐ Yes ☐ No

Emergency Contact _____ Emergency Contact Phone (____)_____-_____

Referred to Office by: ☐ Dr. _____ ☐ Friend/Family _____

Email _____ ☐ Do Not Have Email ☐ Wish Not To Disclose

INSURANCE INFORMATION

Primary Insurance _____ Policy # _____ Group # _____

Insured Name _____ Insured Date of Birth _____

Insured Employer _____ Insured Employer Phone (____)_____-_____

Insured Employer Address _____ City _____ State ____ Zip _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance _____ Policy # _____ Group # _____

Insured Name _____ Insured Date of Birth _____

Insured Employer _____ Insured Employer Phone (____)_____-_____

Insured Employer Address _____ City _____ State ____ Zip _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I agree to pay any balance not covered by the approved medical insurance. If for any reason the account should become delinquent, I agree to pay any interest charges, collection costs, and reasonable legal fees.

Signature _____ **Date** _____

MEDICAL HISTORY

Patient Name:	Date:
Reason for office visit:	Duration of problem:
Your height:	Your weight:

ALLERGIES (LIST ALL KNOWN ALLERGIES OR REACTIONS TO DRUGS/MEDICATIONS)

Penicillin	Sulfa	Local Anesthetic	Iodine
Codeine	Tape/Adhesive	Aspirin	Other Antibiotics

MEDICATIONS (PLEASE LIST ALL CURRENT MEDICATIONS YOU ARE TAKING – INCLUDING PRESCRIPTION AND NON-PRESCRIPTION/OVER THE COUNTER)

MEDICATION	DOSE	MEDICATION	DOSE

What is your preferred pharmacy?

SURGERIES (PLEASE LIST ALL SURGERIES YOU HAVE HAD)

WHAT PREVIOUS TREATMENT HAVE YOU HAD ON YOUR FOOT/ANKLE?
(PLEASE CIRCLE ALL THAT APPLY)

Surgery	Orthotics	Cortisone Shots	Other

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING?
(PLEASE CIRCLE THE CORRECT RESPONSE AND EXAMPLE IF APPLICABLE)

Anemia	Yes	No	Kidney Problems	Yes	No
Arthritis/Rheumatism	Yes	No	Liver Disease or Problems	Yes	No
Artificial Joints (Hip, Knee, etc)	Yes	No	Lung Problems	Yes	No
Bleeding Problems	Yes	No	Neurological Disorder	Yes	No
Cancer	Yes	No	Phlebitis	Yes	No
Circulation Problems	Yes	No	Seizures	Yes	No
Diabetes (Type 1/Type 2)	Yes	No	Stomach Problems (Reflux, Heartburn, etc.)	Yes	No
Fainting Problems	Yes	No	Stroke	Yes	No
Gout	Yes	No	TB	Yes	No
Heart Problems (Attack, Murmur, Disease, etc.)	Yes	No	Thyroid	Yes	No
Hepatitis (A, B, or C)	Yes	No	Transfusions	Yes	No
High Blood Pressure	Yes	No	Ulcers	Yes	No

PLEASE ANSWER EACH OF THE FOLLOWING

Do you smoke or use tobacco?	No	Yes	Previously, but quit	If yes, packs or amount per day:
Do you drink alcohol?	No	Yes	If yes, how often? ☐ Daily ☐ Occasionally ☐ Rarely	
Do you use drugs?	No	Yes	If yes, type of drug and frequency:	
If you are a woman, are you pregnant?			Yes	No
Prior hospitalizations?	If yes, please explain:			
Family Medical History:				

FAMILY PHYSICIAN

Name of Primary Physician: _____
Physician's Address: _____ City _____ State _____ Zip _____
Physician's Phone Number (_____)_____-_____ Date of Last Visit with Physician _____

Leelanau Foot and Ankle Center, P.C.

Sarah D. Miller, D.P.M.

IMPORTANT OFFICE INFORMATION

Welcome to Leelanau Foot and Ankle Center, P.C. We are committed to providing you with the best care possible. Your understanding of our office policies is very important to us. Please read the following information, sign and return it to the front desk. We will be happy to discuss any questions that you may have.

INSURANCE AND CLAIM SUBMISSION: We participate with many insurance companies. As a courtesy, we will bill most insurance companies for our patients. Please understand that your insurance coverage is an agreement between you and your insurance company. Knowing your insurance benefits is your responsibility.

PROOF OF INSURANCE: All patients are required to complete and update our patient information form. You will be asked to verify your address, phone number and insurance information. If you cannot provide up to date health information, you will be responsible for payment in full.

COPAYS AND DEDUCTIBLES: Copays and deductibles are the out-of-pocket expense that you are responsible to pay. Copays may be required for all office visits and follow up exams depending on your insurance coverage. Deductibles are determined by your policy with your insurance carrier. We collect office visit copays on the day of your visit. We cannot write off copays or deductibles because we have signed a contract with the insurance companies that stipulate WE MUST collect copays and deductibles from our patients.

YOUR ACCOUNT: Statements are billed monthly. Payment plans are available based on balance and account history. Accounts that are 90 days past due with no payment history will be turned over to a collection agency. Personal checks that are returned for non-sufficient funds are subject to a $25.00 administrative fee.

MISSED APPOINTMENTS: There will be a $25.00 fee charged to your account if you do not give a 24 hour advance notice of appointment cancelation.

FORMS: There is a charge for the physician to fill out forms. Two pages or less is $10.00. Three pages or more is $25.00. This is due at the time the forms are picked up.

I have read and understand the office policies and agree to abide by the guidelines.

_____	_____	_____
Responsible Party Signature	Relationship	Date

SUMMARY OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices dealing with patient health information. The following material is a summary of that notice and is provided to asset you in understanding it's contents. Please note that a complete copy is available at the reception desk.

Uses and Disclosures of Health Information.

We will use and disclose your health information in order to treat you or to assist other healthcare providers in treating you. We will also use and disclose our health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other healthcare providers. Finally, we may disclose your health information for certain limited operation activities such as quality assessment, licensing, accreditation, and training of residents and students.

Uses and Disclosures Based on your Authorization.

With the exception of the following circumstances, we may not use or disclose your health information without your written authorization:

- For purposes of public health and safety
- For certain limited research purposes
- For government authorities to prevent child abuse or domestic violence
- For government agencies for purposes of their audits, investigations, and other oversight activites
- For law enforcement authorties to protect public safety or to assist in apprehending criminal offenders
- For the FDA to report product defects or incidents
- When required by court orders, search warrents, subpoenas, and as otherwise required by the law

Patient Rights.

As a patient, you have the following rights:

- To have access to your health information
- To request restrictions as to how your health information is used or disclosed
- To receive notice of our privacy practices

Acknowledgement of Notice of Privacy Practices.

I acknowledge that I have received Leelanau Foot and Ankle Center, PC's Notice of Privacy Practices. I have had full opportunity to read and considered the contents of the Notice of Privacy Practices.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Prescription History Consent

I agree Leelanau Foot and Ankle Center, P.C., may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Signature: _____ Date: _____

Parent/Guardian Signature (If patient is a minor) _____

PLEASE READ AND SIGN THIS RELEASE OF INFORMATION SECTION

I, _____ authorize Leelanau Foot and Ankle Center, P.C. to release and/or discuss information relevant to my care to the following individuals:

Name and relationship: _____

Name and relationship: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices, but was unable to do so.

Date: _____ Initials: _____ Reason: _____

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- 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 have to 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 co-pay/co-insurance/deductible.
- 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 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 a service 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 service 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/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- 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 this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____

_____ Patient initials to indicate copy received.

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