Patient Demographic Information: ☐

First Name: _____
Middle Initial: _____
Last Name: _____
DOB: ____/ ____/_____
Sex: □ Male □ Female

Race:
□ White
□ Hispanic
□ Asian
□ African American
□ Other _____

Ethnicity:
□ Not Hispanic or Latino
□ Hispanic or Latino
□ Other _____

SSN: _____/____/_____

Address: _____
City: _____
State: _____
Zip: _____

Language: _____

Marital Status: _____

Pregnant: □ Yes □ No

Employment:
□ Employed
□ Unemployed
□ Student

Employer: _____
Phone: _____
City: _____
State: _____
Zip: _____

Pharmacy:

Name: _____
Location: _____

Patient Contact: ☐

Home Phone: _____
Work Phone: _____
Ext: _____
Cell Phone: _____
Email: _____

Emergency Contact: ☐

First Name: _____
Last Name: _____
Relation to Patient: _____
Emergency Phone: _____
Emergency Address: _____
Emergency City: _____
Emergency State: _____
Emergency Zip:

Insurance: (Please Provide Card) ☐

Primary Insurance: _____
Effective Date: _____
Termination Date: _____
Payer Name: _____
Payer Address: _____
Plan Name: _____
Group Number: _____
Secondary: _____
Insureds ID Number: _____
Co-Pay: _____

Insured's Info: ☐

Patient relationship: _____
First Name: _____
Last Name: _____
Insured's DOB: _____
Insured's Sex: _____
Address: _____
City: _____
State: _____
Zip: _____

OFFICE USE:

Chart Number: _____
Pay Type: _____

How did you hear about our clinic?

Patient: **Date:**

Today's Foot/Ankle Problem(s):			
What is your Foot/Ankle problem?			
When did the problem begin? Please list any previous self and professional treatment?			
Review of Systems:	Mark the following that you **recently** have experienced:		☐
Constitutional:	Chills	Fatigue	Fever
	Weakness	Weight Gain	Weight Loss
Head:	Dizziness	Fainting	Headaches
	Pain	Sweats	
Ears Nose Throat:	Discharge	Bleeding	Infection
	Dentures	Post Nasal Drip	Dry Mouth
	Hearing Aid	Ringing	Lumps
	Sore Throat	Hoarseness	
Respiratory:	Asthma	Bronchitis	COPD
	Cough	Pleurisy	TB
	Wheezing	Short of Breath	
Cardiovascular:	Chest Pain	Hair Loss On Legs	Rheumatic Fever
	Leg or Foot Ulcers	Vascular Grafts	Varicose Veins
	Heart Murmur	Cramps In Legs/Feet	Palpitations
	Extremity(s) Cool	High Blood Pressure	Hx of MI
	Replacement heart valve		
Gastrointestinal:	Constipation	Liver Disease	Excessive Thirst
	Swallowing Problem	Hemorrhoids	Diarrhea
	Rectal Bleeding	Hepatitis	Gall Bladder Disease
	Laxatives	Jaundice	Antacid Use
	Nausea	Heart Burn	
Musculoskeletal:	Arthritis	Joint Pain	Gout
	Lower Back Pain	Knee Pain	Back Problems
	Joint Stiffness	Muscle Cramps	Paralysis
	Restricted Motion	Weakness	Ankle Sprain
	Arch Pain	Broken Ankle	Broken Foot Bone
	Bunions	Calluses	Childhood Foot Problems
	Corns	Flat Feet	Gait (Walking) Problems
	Hammer/Mallet Toes	Heel Pain	High Arch Feet
	In-Toeing	Joint Implants	Muscle Stiffness
	Neuroma	Orthotic Use	Shoe Insert Use
	Toe Walking		
Psychiatric:	Depression	Disorientation	Memory Loss

Skin:	Eczema	Itching	Warts
	Dryness	Hives	Lumps
	Athlete's Foot	Fungal Nails	Ingrown Nails
	Keloid Scar	Mole Changes	Rash
Neurological:	Burning	Fainting	Numbness
	Speech Disorder	Stroke	Tingling
	Tremors	Unsteady Gait	Black Outs
	Charcot Neuroarthropathy	Neuroma	
Endocrine:	Weight Gain	Weight Loss	Fatigue
	Goiter	Sweats	Thirst
	Thyroid		
Hematolgic/Lymph:	Anemia	Bleeding Easily	Blood Cuts
	Easy Bruisability	Swollen Glands	Transfusion Reaction
	Slow Healing Cuts	Recent Chemotherapy	
Allegic/Immunologic:	Hives	Itchy Eyes	Itchy Nose
	Runny Nose	Sneezing	Stuffy Nose
	Watery Eyes	Wheezing	Swelling
Genitourinary:	Blood In Urine	Burning	Excessive Urination
	Flank Pain	Incontinence	Infections
	Retention	Urgency	Kidney Stones
Male:	Hernias	Pain	
	Venereal Disease	Prostate Problems	
Female:	Birth Control	Hernias	Menopause
	Recent Pregnancy	Venereal Disease	Pain
Eye:	Blurred Vision	Cataracts	Contacts
	Eyeglasses	Glaucoma	Infections

Allergies: List any allergies to medications, foods, plants or substances: Reactions? ☐

Medications: List all current medications: (Provide list if available) ☐

Family History: Note family history of any of the following conditions by abbreviation: ☐

Conditions	Relative	Alive/deceased	Age of death
A = **A**rthritis	Mother	**A D**	
C = Cancer: type?	Father	**A D**	
D = Diabetes	Brother/Sister	**A D**	
F = Foot problem(s)	Brother/Sister	**A D**	
G = Gout	Brother/Sister	**A D**	
H = Hypertension			
HD = Heart **D**isease			
S = Stroke			

Medical History:	Have you been treated for:		
Anemia	Anxiety	Arthritis	Asthma
Back Problem	BPH (Enlarged Prostate)	Breast Cancer	Coronary Artery Disease
Cancer	Congestive Heart Failure	Cholesterol High	COPD
Dementia	Depression	Dermatitis	Diabetes
Epilepsy	GERD	Glaucoma	Gout
Headache	Hepatitis	HIV	Hypertension
Migraine	Myocardial Infarction	Pneumonia	Renal Stone
Stroke	TB	Thyroid Disease	Ulcer (GI)

Social History: Check what is pertinent to you:

Tobacco:	Smoke?	Y N	Quit	What:	Amount/Day:	Yrs:
	Oral use?	Y N	Quit	What:	Amount/Day:	Yrs:
Alcoholic beverages:		Y N	Quit	Beer	Amount/Week:	
				Wine	Amount/Week:	
				Liquor	Amount/Week:	

Surgical History: Have you had Surgery? Y or N If yes, what, when, complications:

Notice of Privacy Practices (HIPAA)

We are required to obtain your signature as an Acknowledgement of our Notice of Privacy Practices.
Available with the receptionist is a 4-page copy of our Notice of Privacy Practices, which provides a detailed description of how we are required by federal law to handle your health and personal information. It also informs you on your rights with regards to accessing the information and controlling its disclosure.

I UNDERSTAND I AM ENTITLED TO RECEIVE A COPY OF THE NOTICE OF PRIVACY PRACTICES.

X

SIGNATURE OF PATIENT/PARENT OR RESPONSIBLE PARTY **DATE**

PRINT NAME OF PARENT OR RESPONSIBLE PARTY **RELATIONSHIP**

Practice Policy

CANCELLATION AND LATE VISIT POLICY:
As a courtesy to our other patients, if you are not on time for your appointment it may be necessary to reschedule. We require a 24 hour notice of cancellation. Failure to notify the office will result in a $50.00 fee. This charge cannot be billed to your insurance carrier and will be your responsibility for payment. If cancellation or failure to show for your scheduled appointment becomes a repetitive problem we may terminate the doctor-patient relationship and refer you to another provider.

UNINSURED PATIENT AND MOTOR VEHICLE ACCIDENT POLICY:
If you do not have health insurance or are being seen as a result of a motor vehicle accident, you will be required to deposit $150.00 upon arrival to our office for your initial visit and $75.00 for follow-up visits. Deposits will be offset against balance of charges.

RECORDS AND FORM COMPLETION REQUESTS:
If you request our office to fill out documents, please allow 7-10 working days for this to be completed. Original patient charts and X-rays are the property of the practice and required to remain on-site. Copies will be processed within 7-10 working days and a fee will be charged.

PRESCRIPTION MEDICATIONS:
The providers will only prescribe narcotic pain medication for acute trauma and/or during the immediate period after surgery. If your pain is chronic you will be referred to a pain management specialist. Please allow 48-72 business hours for medication refills. Have your pharmacy electronically notify the office with the medication refill request. No medication refills will occur on weekends or after office hours.

MEDICAL EMERGENCY:
Call 911 or proceed to the nearest emergency room.

HEALTH INSURANCE POLICY:
To accommodate the needs and requests of our patients, we participate with certain insurance plans. We are pleased to be able to provide this service to you, yet it is very difficult for us to keep track of all the individual requirements of each plan as they change from time to time. It is ultimately your responsibility to check with your insurance to understand the contract and coverage. Each plan has different restrictions regarding how often services may be rendered or where you should obtain those services. You must have a referral to our facility with all managed care plans. Each authorization will specify the number of visits and expiration date. The patient is responsible for knowing when this authorization expires. Providing the highest quality of care for our patients is our primary concern. We are more than willing to provide care within your insurance plan guidelines whenever possible. As a surgeon's office, at your request, we will contact your insurance carrier for pre-authorization of surgical procedures. To be sure there are no surprises, please check with your insurance regarding benefits. If you do not inform our billing office of special requirements by you insurance plan and we perform a non covered service, it will be your financial responsibility. All Medicaid patients will need a Healthy Connections referral from their PCP prior to their first appointment.

FINANCIAL POLICY:

- Payment in full is due at time of service unless prior arrangements have been made.
- Any and all co-payments are due prior to any services being rendered. Until co-payments are received, patient will not be seen by the physician.
- If we are a participating provider with your primary health insurance carrier, we will file a claim on our behalf. However, once the insurance company is billed we allow 60 days for the balance to be paid by your insurance carrier. If the insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If any overpayment occurs, you will receive a refund within 30 to 60 days.
- HMO / PPO claim denials due to no referral or authorization, are the patient's responsibility. Office staff will assist you in referral / pre-certification procedures, but final responsibility lies with the patient to comply with their specific insurance carriers requirements. All referrals must be presented to our office prior to seeing the doctor.
- Please inform the staff of change of address and insurance carrier.
- There is a $35.00 charge for all returned checks.
- All unpaid balances are subject to 1.5% monthly interest (18% annually) or a minimum $6.00 service charge, whichever is less, after 60 days from the date of service.
- Please be on time for your appointment. If you need to reschedule your appointment, please call our office 24 hours in advance. There will be a $50.00 charge for appointments missed without a 24 hour notice.
- If your account must be forwarded to a collection agency and or an attorney because of non-payment, you will be responsible for all collection fees and/or attorneys' fees and associated costs.

ASSIGNMENT OF BENEFITS

I, the undersigned do hereby certify that I (or my dependant) have insurance coverage with:

_____

And do assign directly to **Blackmer Foot & Ankle Group, PA** and dba **South Idaho Foot and Ankle** all insurance benefits, payable to me for the services rendered. I also understand that I am responsible for payment of any and all deductibles, co-payments, and/or for any other non-covered services. I so hereby authorize Blackmer Foot & Ankle Group, PA to release all information necessary to secure payment of benefits. I authorize release of medical information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

By my signature I acknowledge receipt of a copy of this policy and hereby agree to its terms.

Signature: _____ Date: _____

Printed Name: _____ Relationship: _____