Ahwatukee Ankle, Foot & Leg Center

15810 S. 45th St., Suite 190, Phoenix, AZ 85048
(480) 893-1090

History & Physical of Patient

Name: _____ Date: _____

Past Medical Conditions: (Circle Yes or No)

AIDS/HIV	Yes	No	Kidney Problems	Yes	No
Diabetes	Yes	No	Bleeding Problems	Yes	No
Type I or Type II Insulin dependant	Yes	No	Lung Disease	Yes	No
Heart Disease	Yes	No	Liver Disease	Yes	No
Gout	Yes	No	Ulcers	Yes	No
Hypertension	Yes	No	Type_____ How Long_____		
Arthritis	Yes	No			

Any Other Medical Problems: (Please List) _____

Family History: _____

Allergies:

Iodine: Yes No Local Anesthesia: Yes No Athletic Tape: Yes No

Any Allergies to Medications: (Please List) _____

Do you Smoke? Yes No How Much? _____

Are you Pregnant? Yes No

Current Medications: (Please List)

_____

_____

Past Surgeries/Hospitalizations: (Please List)

_____

_____

Previous Podiatric Examinations: (List reason for visit – ie: Bunions, Foot Pain etc.)

_____

_____

If you have Diabetes, please list the date you last were seen by your *Primary Care Physician* DR._____ on _____

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PATIENT INFORMATION

Patient Name : _____
Last Name

_____
First Name Middle Initial

SS # _____

Address _____

City _____

State _____ Zip _____

Permanent Address (if different from above) _____

_____

E-mail _____

Sex _____ Age _____ Birth date _____

HT _____ WT _____ Shoe size _____

Marital Status _____

Patient Employer _____

Employer Address _____

_____

Circle Relationship to Insured: SELF SPOUSE CHILD OTHER

Insured/Responsible Party Name _____

Insured/Responsible Party Address _____

_____

Birth date _____ SS # _____

Employer _____

Whom may we thank for referring you?

_____

PHONE NUMBERS

Home Phone ( )_____

Work Phone ( ) _____

Cell Phone ( ) _____

Best time and place to reach you _____

Primary Care Physician _____

Phone Number ( ) _____

Pharmacy _____

Phone Number ( ) _____

Emergency Contact _____

Emergency Contact Phone ( ) _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that a copy of the Notice of Privacy Practices was available to read and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient or Responsible Party

_____

Date _____

I hereby consent that all information provided is current and correct.

Patient Signature _____ Date _____

AHWATUKEE/MARICOPA ANKLE FOOT & LEG
FINANCIAL POLICY

Due to increased insurance company demands, the following policy has been established for this office. There are **no exceptions** to this policy. Please read this policy carefully.

We make every attempt to ensure that all services are compatible with your special insurance requirements. However, all policies have different benefits, depending on the requests and desires of the employer or applicant. Benefits are not always available to all employees, even if they have the same insurance company. Your insurance company informs all participants that it is ultimately your responsibility to know and understand your policy with the insurance company. **We do not have the capability to know each individual policy, as it varies per patient. We cannot guarantee all services will be covered.** It is your responsibility to verify all benefits and coverage information prior to having any services rendered.

Insurance companies require that we submit all claims within a specified time limit. We do our best to follow all guidelines set forth by your insurance company. However, if your insurance changes and you fail to inform us, we may be unable to bill the appropriate company within these time limits. If you do not provide new information, a denial from the previous carrier is our only way of knowing your insurance has changed. Denials are generally not returned to us until after the filing deadline. Therefore if you do not notify us of any changes, you will be responsible for payment of services for your benefits, please notify us of any changes as soon as possible.

You will be responsible for payment of all services if any of the following circumstances apply:

- If you do not have insurance
- If you do not have a referral when required by your insurance company
- If you are with an insurance company we are not contracted with
- If your insurance company denies your claim for any reason that is not resolvable

We do not bill secondary insurance; this is your responsibility- except when Medicare is Primary.

MEDICARE PATIENTS: We are a participating Medicare provider, which means we must bill Medicare directly. Medicare will pay us 80% of the allowable amount *after you have met your annual deductible*. The remaining 20% and deductible are your responsibilities. If you have a secondary insurance plan, we will bill it for you, provided we have your current and complete information. Be aware that if you have enrolled in a Medicare replacement plan, your Medicare part B is now invalid.

A parent/legal guardian must accompany a minor patient on his/her first visit to our office. On subsequent visits, minor patient needs to be accompanied by an adult. The adult accompanying the patient is responsible for the payment of the rendered service at each visit.

- **All co-pays, coinsurance and deductibles are collected at the time of service**.

By signing this form you agree to all the information listed above, authorize the release of any medical information necessary to process your claims and authorize payment of medical benefits to Ahwatukee Ankle, Foot and Leg or supplier for services rendered.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

Print Name

AHWATUKEE/MARICOPA OFFICE POLICIES

Please read carefully and sign below.

APPOINTMENTS:

Dr. Crezee, Dr. Beecroft, and Dr. Stewart are surgeons. They regularly have emergency surgery and emergency walk-ins that can lead to delays. You will be seen as soon as possible, so please be patient. Full attention will be given to you and your needs when the doctor sees you. Thank you for your patience.

We require 24 hours notice for cancelled appointments. Patients who miss appointments **will be assessed a $50 fee**.

BILLING:

Please allow 24-48 hours for billing questions and a return call. Billing frequently requires investigation and research to resolve a problem. When leaving a message, please clearly state your name, patient's name, phone number, and concerns. We prefer to email billing statements. Please provide us with your email address.

There is a $25 fee for all returned checks. Significant outstanding balances will be collected and/or arrangements made for payment before being seen for future visits.

PRESCRIPTIONS:

It is best to discuss your medications with your doctor during an office visit. Please do not let your medication run out. Please notify your pharmacy 3-4 days before you run out of your prescription. If you need a written prescription please allow 24-48 hours for pick-up. We will notify you when it is ready to be picked up. There will be a $20 fee for all prescription prior authorizations.

ORTHOTICS, DURABLE MEDICAL EQUIPMENT & SHOES

Orthotics, braces, splints, boots and post op shoes are **non-returnable and non-refundable.** Please check with your insurance provider for coverage information. If your insurance does not cover them, you are responsible for all charges. There is a $25 fee for all pre-determinations. Once orthotics are ordered, any charges are your responsibility. Charges for braces, splints, boots and post-op shoes that are taken out of our office are your responsibility. There will be a fee for orthotics that are adjusted/repaired after 90 days.

When shoes are purchased, please try them on in the office. Unworn shoes that are taken out of the office may be returned, however, there will be a $15 restocking/shipping charge assessed.

SURGERY

Booking surgery is time-intensive. There will be a $100 charge for cancelling surgery. There will also be a $100 charge for re-scheduling surgery if given less than 48 hours notice.

During the Post-Operative period, patients may still be charged a co-pay or co-insurance for services, depending on your insurance. If services are performed that are not directly related to your surgery, your co-pay and/or co-insurance will be due.

FORMS AND MEDICAL RECORDS

When a physician requests medical records there is no charge, unless the records are in archives. Medical records requested by patients will require a $25-$100 fee depending on how extensive the records are and whether they are in storage. Forms required by Workers Compensation, disability and family leave will require a minimum fee of $25. Compiling medical records is time-intensive and may take several weeks to process. All forms are filled out after hours in the order they are received. A copy of your digital x-rays is $5 per CD.

I have read and understand the office policies:

Patient Signature_____Date_____ Revised 3/1/14

NOTICE OF PRIVACY FOR PROTECTED HEALTH INFORMATION (PHI)

The office of Ahwatukee/Maricopa Ankle, Foot & Leg is dedicated to protect your "nonpublic personal health information." This notice is to tell you how and why we collect that information, and who has access to that information.

HOW WE COLLECT YOUR INFORMATION:

Your personal demographic information such as name, address, birth date, social security number and medical insurance information is obtained from you. This is why we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card. This ensures that the information we collect is correct.

If you came to our practice through a hospital encounter, we may obtain that information from the hospital. However, on your first visit to this office, we will ask you to fill out our information sheet to ensure that the information we received from the hospital is correct. We may also ask a doctor or other health care provider who referred you to this practice to give us health information that will enable us to better treat your medical condition. This benefits you in that we will have test results that have already been obtained by the referring entity.

WHY WE COLLECT THIS INFORMATION:

We collect this information so that we can treat your medical condition and obtain payment from your health insurance.

MAINTAINING ACCURATE AND TIMELY INFORMATION:

To ensure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

WHO HAS ACCESS TO THIS INFORMATION:

Any persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for our services have access to your Protected Health Information. Entities such as Government Oversight Agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners **may** obtain copies of your Protected Health Information. Law mandates these entities and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION:

We release your information only to these people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your health care or entities that need this information for claims processing have access to your Protected Healthcare Information.

COMPLAINTS/COMMENTS:

If you feel your privacy rights have been violated you may file a written complaint at our office or you may contact the practice at (480) 893-1090.

AHWATUKEE/MARICOPA FOOT AND ANKLE CENTER

Patient Name: _____

Date of Birth: _____

HIPAA Acknowledgement

I have received a copy of the Privacy Rules from Ahwatukee/Maricopa Ankle, Foot & Leg, and authorize the following list of people who may receive my Protected Health Information. I understand that I may revoke this authorization at any time by giving written notification to this office.

These people may receive my Protected Health Information:

Name: _____ Date of Birth: _____

Relationship to patient _____ Alternate Phone # _____

Name: _____ Date of Birth: _____

Relationship to patient _____ Alternate Phone # _____

Name: _____ Date of Birth: _____

Relationship to patient _____ Alternate Phone # _____

Name: _____ Date of Birth: _____

Relationship to patient _____ Alternate Phone # _____

Name: _____ Date of Birth: _____

Relationship to patient _____ Alternate Phone # _____

Messages may be left on your answering machine/voicemail regarding: appointments, billing and test results.

Signed: _____ Date:_____

(Patient or parent/legal guardian if patient is minor)