

ADVANTAGE FOOT & ANKLE CENTER

PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Last Name	First	Middle	<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Dr.	Marital Status (Circle One)
			<input type="checkbox"/> Miss	<input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Wid	
Street Address			Birth Date (mm/dd/yyyy)		Sex <input type="checkbox"/> M <input type="checkbox"/> F	
City			State		Zip Code	
Social Security #			Home Phone # ()		Spouse's Name	
Race: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Other:			Ethnicity: <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino		Cell Phone # () AT&T, T-Mobile, Verizon or Other: _____	
Email			Employer		Employer/Work Phone # ()	
Primary Care Physician (PCP)			PCP's Phone #		Date PCP Last Seen	

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN ABOVE)

Name of Person Responsible for Bill	Birth Date (mm/dd/yyyy)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Street Address		Social Security #	
City		State	
Zip Code		Email	
Home Phone # ()		Cell Phone # () AT&T, T-Mobile, Verizon or Other: _____	
Employer	Employer Address		Employer/Work Phone # ()

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND PHOTO ID TO RECEPTIONIST)

Primary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)	Relationship to Patient
Claims Mailing Address	Member ID#	Group #	Co-Payment \$
Secondary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)	Relationship to Patient
Claims Mailing Address	Member ID#	Group #	Co-Payment \$

IN CASE OF EMERGENCY

Name of Nearest Friend or Relative	Relationship to Patient	Home Phone # ()	Work or Cell Phone # ()
------------------------------------	-------------------------	------------------------	--------------------------------

PHARMACY

Name and Address

Phone #

MONTHLY STATEMENTS

_____ Paper _____ Email

The above information is true to the best of my knowledge. I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Advantage Foot and Ankle Center all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. Advantage Foot and Ankle Center may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X _____
PATIENT/GUARDIAN SIGNATURE (Must be 18 or older to sign)

DATE

ADVANTAGE FOOT & ANKLE CENTER FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

1. It is your responsibility to provide accurate insurance information and to present your insurance ID card and Photo ID (required by Federal Law) at the time of your visit. If you do not present a valid insurance card or photo ID, you will be rescheduled.
2. **COPAYMENTS** are due at the time of visit. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurances and deductibles from patients can be considered a violation of the contract you have with your insurance company.
3. **REFERRALS:** If your plan requires a referral, it is your responsibility to obtain this from your PCP prior to being seen by our provider. If you do not have a valid referral, you will be rescheduled. (Referrals are done electronically, PCP must contact insurance company).
4. **SELF PAY PATIENTS:** Payment in full is due at the time of service.
5. As a courtesy, we will be happy to bill your primary and secondary insurance company on your behalf. It is up to each patient to know the rules and limitations of your policies.
6. You are responsible for any portion not covered by your insurance, such as deductible, co-insurance and/or copay. Please read your explanation of benefits to determine amounts owed.
7. If you believe your insurance company has made an error with the processing of your claim, it is up to the policyholder to contact the insurance company to dispute, file a grievance and/or appeal. Please read your explanation of benefits,
8. You are ultimately responsible for payment of charges for services you received from our office.
9. **PATIENT BALANCES:** Payment is due for rendered services 30 days from receipt of your billing statement. Outstanding balances 60 days or older must be paid in full prior to any additional visit.
10. **NO SHOW APPOINTMENTS:** A \$25.00 fee will be charged for any No Show appointments.
11. **COLLECTIONS: Outstanding balances over 91 days old will be sent to the collection agency and charged additional fees.**
12. **BOUNCED CHECKS:** A \$35.00 fee will be charged for any check returned for insufficient funds. Your insurance company does not cover this fee. If this happens, payment will only be accepted by cash or credit card.
13. A scheduled appointment means that time has been reserved for you. Cancellations for appointments must be received at least 24 hours prior to the scheduled appointment.
14. Medical records requests must be received in writing. Fees for medical records are set in accordance with allowable amounts as defined by the State of Delaware. Fees must be received prior to record delivery.
15. Administrative Services: There is a \$40.00 charge for **each** required Administrative Service, payable prior to service completion. This Administrative Service Fee covers specific forms such as FMLA and Short Term Disability and is NOT covered by insurance.
16. In the event your insurance company should happen to send payment to you (the patient), you agree to forward said payment to our office to be applied to your account.
17. Our office accepts, cash, checks (post-dated checks **are not** accepted), and credit cards (Visa, MasterCard, Discover and American Express).
18. If you choose to contact Dr. Bell by text or email, Advantage Foot & Ankle Center is not responsible for any security breach.

I have read and understand the above Financial Policy for Advantage Foot and Ankle Center.

(Signature of Patient, Parent or Legal Guardian (Must be 18 or older to sign))

Date

ADVANTAGE FOOT & ANKLE CENTER

CONSENT TO TREATMENT

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Advantage Foot & Ankle Center Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

AUTHORIZATION REGARDING PRIVACY POLICY

Due to the recent implementation of the Patient Privacy Act (HIPPA), I hereby authorize Advantage Foot & Ankle Center to:

1. Call _____ Home Phone (____) _____ or _____ Cell Phone (____) _____
2. Leave Detailed Message on Answering Machine _____ Yes / _____ No or Voicemail _____ Yes / _____ No
3. Speak with _____ Family Member(s) or Friend
Name: _____ Relationship _____
Name: _____ Relationship _____
4. Appointment Reminders: 1. Text _____ Yes or _____ No 2. Call _____ Yes or _____ No

regarding the following: (1) Change Appointments, (2) Any pertinent information that may be relative to my care, and/or (3) Billing issues.

ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICY

I acknowledge that I was provided a copy of the Advantage Foot & Ankle Centers Financial Policy and that I have read (or had the opportunity to read if I so chose), understand and will comply by the policies stated.

CONSENT TO VIEW EXTERNAL PRESCRIPTION HISTORY

I authorize Advantage Foot & Ankle Center to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and Advantage Foot & Ankle Center and it may include prescriptions back in time for several years.

PATIENT CONSENT

In order for Dr. Jason Bell to evaluate and treat the medical condition(s) I present, I authorize consent to allow for typical examinations, review of diagnostic testing, administration of medications, application of medical products, and all other pertinent care with reason of the practice of foot and ankle medicine. I agree to ask questions to clarify treatment should I not understand the treatment plan.

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Advantage Foot & Ankle Center all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I agree that should my account become delinquent and is referred to an attorney or collection agency for collection, I will be charged an additional fee of any unpaid balance at the time of referral for all costs of collection and attorney's fees. I authorize the use of my signature below on all insurance submissions.

Advantage Foot & Ankle Center may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

DISCLOSURE OF SERVICES

I understand that Advantage Foot & Ankle Center is owned and operated by Dr. Jason Bell. During my course of treatment, products and/or services from this business may be recommended. I understand that I am under no obligation to patron these businesses and that I may find alternate sources to purchase these products and/or services.

I have read and fully understand this Consent to Treatment. This authorization is valid as of the date I have signed below and will remain in effect as long as I am a patient of Advantage Foot & Ankle Center. I have read this complete page and agree to all of its contents.

PRINT Name of Individual/Legal Representative

SIGNATURE of Individual/Legal Representative

Date

ADVANTAGE FOOT & ANKLE CENTER COMPREHENSIVE MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

HISTORY OF PRESENT ILLNESS / WHAT BRINGS YOU IN?

What is your specific foot/ankle problem? _____

Which foot/ankle is involved? Right Left Both

First visit to a doctor for this problem? Yes No

Have you had a similar problem in the past? Yes No

When did the problem begin? _____

How was the problem onset? Sudden Gradual

The problem is: Improving Worsening Unchanged

The problem is worst: AM PM At Rest With Activity

What aggravates the problem? _____

What improves the problem? _____

Is the problem painful? Yes No If so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain: Sharp Dull Aching Throbbing Cramping Itching Popping
 Burning Tingling Clicking Shooting Stabbing Other: _____

Describe previous treatments: _____

Is this from a Work Related injury? Yes No Is this from an Auto Accident? Yes No _____

PAST MEDICAL HISTORY

- Diabetes Type 1 2 Duration _____ years Last Blood Sugar _____ HbA1c _____
- Acid Reflux Liver Disease (Hepatitis)
- Anemia Leg Cramps/Leg Pain at Rest
- Anesthesia Complications Lung Condition: _____
- Arthritis (Osteo / Rheum) Mitral Valve Prolapse/Murmur
- Asthma Multiple Sclerosis
- Back Problems/Sciatica Nervous Disorder/Depression
- Blood Clot/DVT Neuropathy
- Cancer: _____ Osteomyelitis/Bone Infection
- Cellulitis/Skin Infection (MRSA?) Pacemaker
- Circulation Problem Parkinson's Disease _____
- Defibrillator Previous Addiction to:
- Dementia/Alzheimer's Pulmonary Embolism
- Dialysis Rashes/Skin Condition
- Excessive/Easy Bleeding Raynauds Disease/Phenomena
- Fibromyalgia Seizure Disorder/Epilepsy
- Foot/Leg Ulcer Sickle Cell Disease/Trait
- Gout Sleep Apnea
- Healing Problems/Keloids Stomach Ulcers _____
- Heart Disease/Heart Attack Stroke Rt Lt year
- High Blood Pressure (Low BP?) Thyroid Condition (Hi Lo)
- Immune Disorder/HIV Women – Are You...
- Kidney Disease Pregnant?
- Breastfeeding?

LIST ALL PREVIOUS SURGERIES

FAMILY HISTORY (circle relative)

Mother Father Sister Brother GrandParent

Cancer M F S B GP

Diabetes M F S B GP

Heart Disease M F S B GP

High Blood Pressure M F S B GP

Anesthesia Complications M F S B GP

Other: _____ M F S B GP

Other problems not listed above: _____

ADVANTAGE FOOT & ANKLE CENTER COMPREHENSIVE MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

MEDICATIONS (include all meds, RX, OTC's, vitamins) ALL MEDICATIONS/VITAMINS, etc MUST BE WRITTEN ON THIS FORM "SEE ATTACHED" NOT ACCEPTABLE

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Adhesives/Tape | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetics ____ Lidocaine ____ Epinephrine |
| <input type="checkbox"/> Aleve | <input type="checkbox"/> Motrin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Cortisone | <input type="checkbox"/> Seafood/Shellfish |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Sulfa Drugs |
| | <input type="checkbox"/> OTHER _____ |

SOCIAL HISTORY

Occupation: _____

I Drink Alcoholic Beverages How much/often? _____

I Use or Have Used Tobacco Products Type: _____
Packs/Day _____ Years _____ When Stopped? _____

I Use or Have Used Illegal Drugs

Do you see Pain Management? Yes No Name and Phone # _____

STATS

Age _____ Height _____ Weight _____ Shoe Size _____

I understand that completing this paperwork is a chore. The information I have provided is true to the best of my knowledge. I recognize that the information I have provided will help me receive better care. I thank you for taking such an interest in my health.

X _____

PATIENT/GUARDIAN SIGNATURE (Must be 18 or older to sign)

DATE