

GOLDEN TRIANGLE FOOT & ANKLE SPECIALISTS, P.A.

****PLEASE PRINT****

DATE _____ EMAIL ADDRESS _____

PRIMARY PHONE # _____ ALTERNATE PHONE # _____

PATIENT NAME _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

SEX M F AGE _____ DATE OF BIRTH ____-____-____ SINGLE MARRIED WIDOW
 DIVORCED SEPARATED

Race _____ Ethnicity _____ Primary Language _____

SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____

WERE YOU INJURED AT WORK? _____

Preferred Contact Method: Phone/Mail Preferred Reminder Method: Cell# Home# Work# EMail
(circle one) (circle one)

PATIENT EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

NAME OF PRIMARY INSURANCE _____ IS REFERRAL REQUIRED? _____

NAME OF SECONDARY INSURANCE _____ IS REFERRAL REQUIRED? _____

NAME OF INSURED _____

INSURED DATE OF BIRTH ____-____-____ EMPLOYER _____ WORK# _____

RELATIONSHIP TO PATIENT _____ SOCIAL SECURITY # _____

EMERGENCY CONTACT _____ PHONE# _____

WHO IS YOUR FAMILY DOCTOR? _____ PHARMACY _____

Due to Doctor/Patient **CONFIDENTIALITY**, this office is not allowed to release any information, written or by phone regarding your condition without written consent from you. Often times, family members will phone the office regarding your visit. Please sign below indicating **YOUR PREFERENCE**. Also, please supply us with a list of those persons to whom we can release information. **If the patient is a minor, signature should be the responsible party.**

PATIENT SIGNATURE: _____

I **DO/DO NOT** (please circle) give permission to release my medical information to the following persons:

PERSONS NAME

RELATIONSHIP TO PATIENT

GOLDEN TRIANGLE FOOT & ANKLE SPECIALISTS, P.A.

I understand that honest and complete answers to each question stated below are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form, I should ask the doctor or a member of the office staff for assistance.

YES NO

Is the patient currently a resident of a Skilled Nursing Facility?

Are you now, or have you been in the past 2 years, under the care of a physician for any reason?
If so, for what illness? _____

Do you have diabetes?
What year were you diagnosed? _____

Are you on any medications for **DIABETES**?
Name and dose of medication: _____

What is your blood sugar normally? _____

Can you take Aspirin products?

Do you have any history of bleeding ulcers or hiatal hernia?

Have you ever experienced any side effects from anesthesia?

Have you been treated for any of the following?

Heart Problems

Asthma

Blood Born Illness, i.e. *HIV / Hepatitis A, B, C*

Do you have a family history of any of the following?

Diabetes

Gout

Heart Trouble

Varicose Veins

Neuromuscular Disease

Peripheral Vascular Disease

Do you consume alcohol? Amount: _____

Do you use tobacco? Amount: _____

Please answer the following questions as completely as possible.

What is your current foot problem? _____

Is your foot problem related to a work injury? _____

Height: _____ Weight: _____ Shoe Size: _____

Surgeries: _____

GOLDEN TRIANGLE FOOT & ANKLE SPECIALIST, P.A.

Policies That May Affect You:

Work Related Injuries

Podiatry Associates does not treat work related injuries.

Referrals

If your insurance company requires a referral, **YOU** are responsible for obtaining it. Failure to obtain the referral may result in lower or NO payment from the insurance company. This will leave a balance that is your responsibility.

Toenail Trimming

Medicare does **not** pay for toenail trimming unless the patient meets specific criteria.

If you **do not** meet the criteria and would like to have your toenails trimmed, we will collect **\$40.00** at the time of service.

Secondary Insurance

We will file secondary insurance for you.

In order to do this we must have that information **BEFORE** you see the Doctor.

It is not unusual for secondary insurance to not respond to the claim, pay part of the claim, or pay nothing on the claim. Of course if that should occur the balance is your responsibility. We will give your secondary insurance sixty days to pay the claim before sending you a bill.

Signature

Date

GOLDEN TRIANGLE FOOT & ANKLE SPECIALIST, P.A.

Financial Policy

Procedures in the office are generally *not* covered under your office visit co-pay. They are generally applied to your deductible.

Examples:

Surgical procedures in the office

Ingrown toenail procedure

Custom Molded Orthotics

X-rays

Ultrasounds

Injections

Durable Medical Equipment

Surgery in a facility

If the procedure or service is applied to your deductible then payment is your responsibility.

Your covered medical expenses are based on the contract between **You and **Your** insurance carrier.**

Our office will **try** to verify your insurance coverage and collect the necessary co-pay, deductible and/or co-insurance amounts. Although we may **estimate** what your insurance company will pay, it is the insurance company that makes the **final determination** of benefits. Therefore, it is possible that you may be responsible for more than initially estimated.

We will collect for surgeries to be performed in a surgical facility or hospital when it is scheduled.

If you have a balance on your account we will send you a monthly statement. Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued. Delinquent balances will be sent to a collection agency.

I authorize the release of any medical information necessary to pay this claim and authorize Dr. Burrell and Dr. Lusk to apply for benefits on my behalf for services rendered. I request that payment from my insurance company be made directly to Dr. Burrell or Dr. Lusk. I certify that the information I have furnished with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original.

Signature

Date

Patient Medication List

**Please list all medications, herbal supplements
and/or vitamins that are taken daily**

Patient Name _____ Date of birth: _____

Drug Allergies _____

<u>Medication & Dosage</u>	<u>Frequency</u>	<u>Doctor that prescribes this for you</u>
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

GOLDEN TRIANGLE FOOT & ANKLE SPECIALISTS, P.A.

NEIL A. BURRELL, D.P.M.

DEBRA J. LUSK, D.P.M.

KOLBY S. WHITE, D.P.M.

WELCOME TO OUR OFFICE!

We would like to thank you for choosing our office for your podiatric needs. As often happens in offices, patients usually have questions regarding office appointments, etc., and we would like to take this opportunity to explain them to you so there will be no misunderstanding later.

This information is for new AND established patients:

** You are considered a “new” patient if we have not seen you in at least 3 years. This means that you will receive a bill with “new patient” charges on it. This is standard procedure for all medical offices as directed by the federal government. You must see the doctor at least once a year in order for your prescriptions to be filled.

(Initial)
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FINANCIAL INFORMATION:

Our office staff will be happy to discuss our fees with you **PRIOR** to seeing the doctor. We want our patients to understand our fees and feel confident that they are getting the best medical care available for their dollar. **PAYMENT IN FULL WILL BE REQUESTED FOR EACH VISIT BEFORE YOU LEAVE** if you are not on one of the insurances that we are in network with. You will be provided with a detailed itemization of charges at the time of payment for this visit. You will receive two copies: one for you to file with your insurance, and the other for you to keep for your records. We suggest you keep this record of your visit, which will also indicate that your account is paid in full. You will also be given an appointment card as a reminder of any future appointments if needed.

NO PAYMENT ARRANGEMENTS WILL BE MADE FOR NEW PATIENTS.

(Initial)

ACCEPTED FORMS OF PAYMENT: CASH, CHECK OR CREDIT CARD (VISA, MASTERCARD OR DISCOVER)

****INSUFFICIENT FUNDS CHARGE IS \$25.00**

Signature

Date

INSURANCE:

If you are on an H.M.O. or any insurance plan that requires referral from your primary care doctor to see a specialist, it is *YOUR* responsibility to get that referral before your visit in our office. You will also be expected to pay your co-pay upon arrival or you will have to reschedule your appointment.

(Initial)
.....

We want to reiterate to you that payment for services received by you or your family members is your **sole responsibility**. **Payment is due in FULL at time services are rendered** if we do not accept your insurance or if you have a deductible on your insurance that has not been met.

(Initial)
.....

DIVORCE:

Please remember that divorce is a civil action between husband and wife. Your bill is still payable and due. Federal and State laws supersede divorce actions. Divorce does not cancel financial responsibility for your minor children *you* bring in for treatment.

(Initial)
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NOT SHOWING FOR SCHEDULED APPOINTMENT:

This is extremely troublesome for us. We realize that sometimes “things” come up and you are unable to keep an appointment. **PLEASE CALL AT LEAST 24 HOURS IN ADVANCE IF AT ALL POSSIBLE TO CANCEL AN APPOINTMENT.** We reserve the **right to discharge you as a patient if you “no show” for your appointment two or more times.**

(Initial)

We do attempt to call to remind you of the appointment, but ultimately it is the patient’s responsibility to remember.

(Initial)

MEDICAL RECORDS:

This office holds your medical records in the strictest confidence. They will not be released to **anyone** (including you) without your *explicit written permission*.

The medical records processing fee is \$25.00. Medical records requests will be processed within 15 days of receipt of the written request and pre-payment.

(Initial)

BILLING RECORDS:

Billing records are processed in the same manner as medical records, but there is usually no fee associated for providing these records to you.

(Initial)

DISABILITY AND INSURANCE FORMS:

There is a \$25.00 processing fee for completing disability and insurance forms. Should your insurance or disability company require medical records and/or billing records, the fees for those services will also be charged.

(Initial)

SIGNATURE

DATE