

ADVANCED FOOT CARE, LLP ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

My signature at the bottom of this form authorizes payment for services rendered to myself or my dependant to be made directly to Advanced Foot Care, LLP. This authorization is valid until I notify Advanced Foot Care in writing that it is revoked.

I understand that I am responsible for giving “Advanced Foot Care, LLP” the correct insurance information at the time services are rendered. Advanced Foot Care, LLP agrees to bill your primary insurance carrier. If you have more than one insurance we will bill your secondary insurance one time as a courtesy. If payment is not received from your secondary within 45 days the balance becomes your responsibility. All insurance information must be provided to our office, at the time of service.

I understand that I am responsible for obtaining the proper referral and may be held responsible for charges not covered by my Insurance due to my failure to obtain the required referral.

I agree to pay for non-covered services under my insurance plan (services for which I have a policy exclusion).

I understand that Advanced Foot Care, LLP is not responsible for knowing if the group/physician is a participating provider with my insurance carrier.

We at Advanced Foot Care, LLP expect that all accounts should be paid by the receipt of the first two statements. If your account has not been settled either by payment in full or by contacting our billing department to set up a payment plan we will be charging a \$10 re-billing fee, for each statement that we mail. If you have made arrangements with our office we will not charge the re-billing fee for statements sent. Your account will be turned over to collection if you do not fulfill the terms of your financial arrangements.

I understand that there is a fee \$25 fee for all returned checks.

I understand that if I do not call to cancel my appointment within 24 hours there will be a \$25 fee applied to my account.

I understand that I am responsible for all balances not paid by my insurance carrier, including deductibles, co-pay, and co-insurance and out of network penalties. I further understand that if this balance is turned over to an outside collection agency that I shall be liable for all costs of collection and any attorney fees and or court costs incurred by this office.

Patient or Patients Guardian or Legal Representative Signature Date

Name of Patient or Guardian or Legal Representative Relationship to patient

History & Medical Information

1. Primary Care Physician: _____
 Phone Number: () _____ Date of last visit: _____

2. Explain your foot/ankle problem: _____

3. When did pain/discomfort begin? (date): _____
 Describe pain/ discomfort: Burning Numbness Sharp other: _____

4. What makes pain/discomfort better?: _____

5. What makes pain/discomfort worse?: _____

6. Has condition been treated?: YES NO When and how: _____

7. Past Medical History:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other Arthritis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lung Disorders | <input type="checkbox"/> Prostate Disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Nerve Disorders | <input type="checkbox"/> Thyroid Disorders |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV/ Aids | <input type="checkbox"/> Neurologic | <input type="checkbox"/> Stroke |
| | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Other: _____ |

8. List all Medications/herbs/vitamins: None

What is your Pharmacy name? _____ Phone # _____

9. Allergies: None

<input type="checkbox"/> Penicilin	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Shellfish
<input type="checkbox"/> Narcotic Agent/ Codeine	<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Radiographic Contrast/ Dyes	

10. Surgical History:
 Have you had Surgery: YES NO
 Describe:(surgery/date): _____

11. Social History:

<input type="checkbox"/> Tobacco Use*	<input type="checkbox"/> Alcohol use	<input type="checkbox"/> Exercise Habits _____	* If Yes How Much? _____
<input type="checkbox"/> Caffeine Use	<input type="checkbox"/> Drug Use (recreational,IV)	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Nursing

12. Occupation/Job: _____

13. Family history: (list relationship of member(s) who have had problems)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Cancer
<input type="checkbox"/> Rheumatology	<input type="checkbox"/> Other Family History: _____		

Advanced Foot Care, LLP Review of Systems

1. Constitutional Symptoms:

- Fevers Chills Sweats Weight Loss NONE

2. Head, Eyes, Ears, Nose and Throat: Do You...

- Wear: Contacts Dentures Eyeglasses NONE
 Have: Double Vision Cataracts Dizziness Ringing in Ears
 Difficulty Swallowing Neck Pain Sore Throat
 Nose Bleeds NONE

3. Cardiovascular:

- Chest Pain/Heart Attack Congestive Heart Failure Heart Murmur Palpitations
 Swelling in Legs/Ankles Leg Pain w/ Exercise Cardiovascular Surgery NONE

4. Hematological/Lymphatic (blood) History of:

- Bleeding abnormalities Anemia Lump In Groin or Armpit Lymphoma
 Swollen Glands NONE

5. Respiratory:

- Shortness of Breath Emphysema Cough Bronchitis
 Difficulty Breathing Wheezing Asthma Previous Pulmonary Disease
 TB (tuberculosis) Exposure or Treatment Pneumonia NONE

6. Gastrointestinal:

- Nausea Vomiting Diarrhea Constipation Stomach Ulcers
 Decrease in Appetite Blood in Stool Hepatitis Acid Reflux NONE

7. Endocrine:

- Often Thirsty Often Urinating Kidney Disease Pancreatitis
 Diabetes Mellitus Prostate Problems Thyroid Disorder NONE

8. Musculoskeletal:

- Tendonitis Bursitis Broken Bones Arthralgia
 Weakness Of limbs Feeling Weak Joint Pain NONE

9. Nervous System: History Of...

- Migraines Seizures Strokes Nervous Disorders
 Ataxia (loss of balance) Aphasia (loss of speech) Confusion Fainting
 Neuropathy (loss of sensation) Speech Difficulties NONE

10. Integumentary:

- Rash Skin Ulcers Lesions Sensitivity to Sun
 Change in Skin Color Growth on Skin Recurrent Infections Cracking of the Skin
 Eczema Keloid Hair Loss NONE

11. Psychiatric: History Of...

- Nervousness Tension Depression NONE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient/Guardian Signature: _____ **Date:** _____

Doctor's Review; Doctor Signature: _____

Date: _____

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

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

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature

**** *Packets are available at the front window.***
