# PATIENT INFORMATION

Patient Name _____ Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip Code _____

Phone Number (_____) _____ Cell Phone (_____) _____

Gender: Male ☐ Female ☐

Height ____Ft____In_____ Weight _____Shoe Size _____

Race _____ Ethnicity _____ Language _____

Patient SSN _____-_____-_____ Marital Status _____

Email Address _____

Employer Name _____Employer Phone _____

Employer Email Address _____ Work Title _____

---

Family Physician _____ Practice Name _____

Phone Number (____) _____ Fax Number (____) _____

---

Preferred Pharmacy _____ Phone Number (____) _____

Major Crossroads _____

---

**I certify that the above information is accurate to the best of my knowledge.**

Patient/Guardian _____ Date _____

# History & Physical

Patient Name _____ Date of Birth _____ Age _____

## Past Medical Conditions (Please check all that apply)

| | |
|---|---|
| ☐ AIDS/HIV | ☐ ARTHRITIS |
| ☐ DIABETES | ☐ KIDNEY PROBLEMS |
| ☐ HEART DISEASE | ☐ BLEEDING PROBLEMS |
| ☐ GOUT | ☐ LUNG DISEASE |
| ☐ HYPERTENSION (HIGH BLOOD PRESSURE) | ☐ LIVER DISASE |
| ☐ OTHER: _____ | ☐ ULCERS |

Past Surgeries / Hospitalizations:

_____

_____

_____

Family History (All Medical Conditions):

_____

_____

_____

## Social History (Please check all that apply)

☐ Please check your current Tobacco status. ____ Current ____ Never ____ Former

☐ Do you use Alcohol? ☐ No ☐ Yes

☐ Currently Pregnant

**Current Medications:** ☐ **NONE**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

**Allergies:** ☐ **NONE**

_____

_____

_____

_____

_____

# Cactus Foot and Ankle Financial Policy and Authorizations

We are happy that you selected Cactus Foot and Ankle for your healthcare needs and look forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.

Patients are expected to provide identification and if insured, a current insurance card(s) at time of service. Patients are financially responsible for all services provided and are expected to pay for services at time of service, including co-pays, deductibles, and any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship. Returned checks will be subject to fees.

** If your deductible has not been met, we will collect for the services immediately following your appointment. By signing this authorization and consent, you agree to pay for all amounts due for services rendered, in full, immediately following the appointment. Any overpaid amount will be mailed out to you via check. **Please keep in mind that our billing department is a separate entity. Once our office receives an EOB/statement from our billing department for overpayment, the check will be mailed out within 30 days.

**Medicare:** The office will bill the Medicare intermediary. Patients are responsible for the following:

- Annual Medicare deductible
- All applicable co-pays of the allowed charge
- Any non-covered services
- Any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice (ABN).

**Medicare Supplemental and Secondary Insurances:** The Practice will bill both Medicare and secondary insurances.

**Medicaid:** Patients must provide the Practice with a current Medicaid card at each visit. Medicaid patients are responsible for applicable co-pays and for all non-covered services. Medicaid patients are responsible for securing necessary referrals from their primary care physicians.

**HMOs and PPOs, Commercial Insurance Plans:** Patients are responsible for payment of the co-pay, co-insurance and/or deductible, or non-covered amounts at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the Practice. Patients are responsible for the balance in full if not paid by the insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, the appointment will be rescheduled.

**Self-Pay:** Patients are responsible for payment in full at the time of services for all services rendered.

**Worker's Compensation:** Employer authorization must be obtained before treatment is rendered or the patient will be responsible for payment in full at the time of services for all services rendered. Once authorized, patients are not responsible for any charges unless the workers compensation case is dismissed or denied.

**Personal Injury/Motor Vehicle Accidents and Other Third-Party Liability:** The patient is responsible for the balance in full at the time of service. Any settlement you receive from your insurance company or other third party will be handled by you, your insurance company, and/or your attorney.

**Out of State Insurance:** If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patient's benefits for out-of-state or out-of-network benefits. The patient may be required to make payment in full or pay any co-pay, co-insurance, or deductible.

# Authorizations and Consent

**ASSIGNMENT AND RELEASE**: I hereby assign my insurance or other third-party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

**ELECTRONIC CHECK CONVERSION:** When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day. All returned checks will be subject to a $50 fee.

**CONSENT FOR TREATMENT:** I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

**NO SHOW POLICY:** I understand if I fail to come for a scheduled appointment or cancel at least 24 hours prior to the appointment, I will be considered a "no show." Ongoing occurrences of no shows may result in dismissal from the Practice.

---

******PLEASE INITIAL ALL OF THE FOLLOWING:***

_____ I have read and understand the Financial and No-Show Policies, Authorizations and Consent for Treatment, and hereby agree to them.

_____ I am aware that benefits are determined by my insurance company and not by the provider and understand that verification of benefits is not a guarantee of coverage or payment.

_____ I understand the provider is not responsible for the misquotation of benefits from my insurance company and that insurance benefits are determined by my insurance company when the claim is received.

_____ I understand that I am responsible for all charges if it is determined that the insurance information I have provided to Cactus Foot and Ankle is incorrect.

_____ _____

Patient or Parent/Guardian Signature Date

**I hereby authorize Cactus Foot and Ankle to leave a detailed voice message on my answering machine regarding any medical information they may have. The number (s) acceptable to leave a voicemail are:**

Home Phone: _____

Cell Phone: _____

Alternative Phone: _____

**Please provide us with the names of any person or persons are allowed to share your medical information with, otherwise we may not do so even with a spouse or relative without this authorization.**

I hereby authorize:

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

to receive any information concerning my medical condition or treatment at Cactus Foot and Ankle.

Patient Signature: _____

Date: _____

Patient's Printed Name: _____

# HIPPA PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

**We have adopted the following policies:**

**1**. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

**2**.It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

**3.**The practice utilizes several vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

**4.**You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

**5.**You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

**6.**Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

**7**.We agree to provider patients with access to their records in accordance with state and federal laws.

**8**.We may change, add, delete, or modify any of these provisions to better serve the needs of the both the practice and the patient.

**9.**You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

**10**. Any information you do not wish to disclose must be specified in writing. Any information being requested to be released to anyone besides a referring/treating physician must be submitted in writing.

**I, _____, date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA PRIVACY PRACTICES form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

# SHORT TERM DISABILITY/FMLA/PHYSICIAN STATEMENTS/PHYSICIAN LETTERS

Below is our office policy regarding all requests for Short Term Disability/FMLA/Physician Statements/Physician Letters or any other forms that must be completed by the physician.

- All forms must be given to the front desk to log. Each request will incur a processing fee of $25, which must be paid in full for the paperwork to be completed. These forms or requests can be sent to our office via fax, email, or hand delivered. An intake form will need to be completed and attached to the form along with your payment.
- All forms will be processed and completed by the assigned Physician/Medical Assistant within 7-10 days of receiving the paperwork and payment.

***<u>**Forms will NOT be completed on the same day that they are dropped off. Please plan accordingly.**</u>

- If you have more than one disability company, each set of forms from each company will incur a $25 fee. Again, this MUST be paid in full for the paperwork to be completed.
- FMLA forms for a family member will also be subject to a $25 fee and must be approved by your doctor. Some forms for family members cannot be completed by our office and will be denied. The physician will make that decision after reviewing the documents.
- If you are currently having your disability forms done by your Primary Care Provider and are coming to see us as a new patient, you must continue to have these forms completed by you Primary Care Provider.
- Our office cannot complete permanent disability forms, we can only complete Short Term Disability requests. All permanent disability requests will be **denied**.

***I have read and understand the policy for Short Term Disability/FMLA/Physician Statements/Physician Letters***

_____ _____

Patient or Parent/Guardian Signature Date

# PHYSICIAN DISCLOSURE

As required by Section 32-1404 (27) (ff) of the Arizona Revised Statutes

Arizona law requires a physician to disclose to a patient those arrangements permitted under applicable Arizona law whereby such a physician has a direct financial interest in a separate diagnostic or treatment agency, or in non-routine goods and services for which the patient is being referred. The purpose of this Disclosure is to notify you, the patient, that your attending physician(s) may receive remuneration for referring you to its affiliate's entities, for certain services, such as physical and occupational therapy, orthotics, durable medical equipment, medical imaging, pharmacy, laboratory, and other diagnostic and treatment modalities, and that these treatments or services are available on a competitive basis.

Accordingly, I hereby acknowledge that my attending physician(s) disclosed to me, at the time of initial contact and at the time of referral (i) his or her affiliation, if any, with the affiliates entities for whom, I, the patient am being referred, and (ii) that he/she may receive, directly or indirectly, remuneration for the referral to such services provided by these entities. I understand that I, the patient, have the right to choose the providers of my health care services and/or products and, as such, I have the option of receiving services from any provider that I choose.

_____ _____

Patient or Parent/Guardian Signature Date