HOSEY FOOT AND ANKLE CENTERS
PODIATRISTS-FOOT SPECIALISTS

Welcome to our office

Today's Date: _____ Pharmacy:_____
Emergency Contact: _____ Phone:_____
Phone #: _____ Location:_____
Patient Email Address: _____ Social Security#:_____
Are you interested in receiving our newsletter, if so Emailed or Mailed:_____

Who referred you to our office: _____

Patient Information
Last Name: _____ First Name: _____MI: _____
Address: _____Apt./Unit: _____
City: _____ State: _____Zip Code: _____
Home Phone: _____ Cell Phone: _____Work: _____

Appointment Reminder Preference: Phone Call: _____ Text Message: _____

Date of Birth: _____ Gender: M F Marital Status: Single ___ Married ___ Other ___
Employer: _____ Occupation: _____
Preferred Language: _____
If Married, Spouse's Name: _____ Date of Birth: _____

Race (Select all that apply)
African American
American Indian/Alaskan Native
Asian
Caucasian
Native Hawaiian / Pacific Islander
Other / None of the above
Decline to answer

Ethnicity (Select One)
Arab Descent
Hispanic / Latino
Other / None of the above
Unknown
Decline to answer

Responsible Party Information (for minors):
Last Name: _____First Name: _____MI:_____
Address: _____Apt./Unit ____
City: _____State: _____Zip: _____
Date of Birth: _____ Sex: M F Social Security # :_____

Primary Insurance Company
Insurance Company: _____
Subscriber's Name: _____ Date of Birth: _____
Secondary Insurance Company
Insurance Company: _____
Subscriber's Name: _____ Date of Birth: _____

HOSEY FOOT AND ANKLE CENTERS

Medical Information:

Patients Family Doctor: _____ Phone: _____
Please list medications you are ALLERGIC to: _____
_____
Please list medications you take regularly: _____
_____

Do you have diabetes? ____ What medications are you taking for diabetes:_____
Is there a family history of diabetes? _____
List any past surgical history: _____
If you have had or have any of the following, please circle:
Heart Trouble _____ Please Explain: _____
Anemia: _____
Kidney Trouble: _____
Circulation Disease: _____
High Blood Pressure: _____
Rheumatic Fever: _____
Cancer: _____
Stomach Ulcers: _____
Epilepsy: _____
Prolonged Bleeding: _____
Psychological: _____
Asthma: _____
Hepatitis: _____
Liver Trouble: _____
AIDS: _____
Cramps or Numbness in feet or legs: _____
Any other conditions not listed above: _____

Are you Pregnant ? _____ Tobacco Use: ____yes____no How much ?_____
Alcohol Consumption ? _____yes _____no How Much ? _____
My Foot / Ankle problem is: _____
_____
How long have you had this problem ? _____
_____
Additional comments: _____
_____
Signed: _____ Date: _____
If signed as Parent/Gaurdian, state relationship to patient: _____

Family History

	Mother	Father	Sister	Brother	Maternal Grandparents	Paternal Grandparents
No Problems						
Hypertension						
Cholesterol						
Diabetes						
Coronary Disease						
Stroke						
Breast Cancer						
Colon Cancer						
Melanoma						
Ovarian Cancer						
Prostate Cancer						
Other Cancer						
Aneurysm, Abdominal/Aortic						
Aneurysm, Cerebral						
Auto Immune Disease						
Blood Clotting Disorder						
Hemochromatosis						
Hypothyroidism						
Multiple Sclerosis						
Osteoporosis						
Mental Health Disorder						
Other						

Financial Policy
Thomas C. Hosey DPM & Associates

When both you and your health insurance company pay part of your medical expense, it's called cost sharing. Deductibles, coinsurance and co-pays are all examples. Understanding how they work will help you know when and how much you have to pay for care.

- **Deductible** is the amount you pay for health care services before your health insurance begins to pay.
- **Coinsurance** is your share of the costs of a health care service. It's usually figured as a percentage of the total charge for the service. You start paying coinsurance after you've paid your plan's deductible.
- **Copay** is a fixed amount you pay for a health care service, usually when you receive the service. The amount can vary by the type of service.
- Payments of all co pays, deductibles, and/or coinsurance are due at the time of service. As a service to you, our office will bill your insurance company. Being a participating provider with most insurance companies, the insurance companies require that we collect these fees, as they are terms of your health care contract. Additionally, patients are ultimately responsible for all balances.

- For your convenience, we accept cash, checks, credit cards including Visa, MasterCard, American Express, Discover, and Debit Cards.

- Due to the constant changes in health insurance it is your responsibility to know your health coverage. If you need a *referral or authorization* to be seen, please have it available for your appointment. Should have any questions regarding if a certain procedure is covered, it is to your advantage to call your insurance company and find out exactly what your contract covers. Their customer service representatives will be happy to assist you.

- **Insurance Claims** Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company does not pay for any of your services performed at our office, you may be responsible for the complete balance of the non-payable services. If we are out of network with your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. **It is your responsibility to contact your insurance carrier.**

- Because of the government's aggressive approach to ensure that all claims are billed correctly. According to the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Federal False Claims Act, and the Federal Anti-Kickback Statute.
- "It is unlawful to routinely waive co-payments, deductibles, coinsurances or other patient responsibility payments." (67 Fed. Reg. 72,896
- Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)\ it is now a federal crime to defraud private insurance companies. Violations can result in fines and criminal prosecution.

- **I, _____ have read the above financial policy and understand my financial responsibility to my health-care provider. This policy replaces any prior financial policy signed and will be strictly enforced.**

- _____ _____
- Patient Signature Date Witness Date

HOSEY FOOT AND ANKLE CENTERS

PATIENT NAME _____

PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT: I hereby consent to the treatment provided by Hosey Foot and Ankle Centers and is its employees or designees.

_____
(initials)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION: I authorize use and disclosure of my personal health information for the purpose of conducting the health care operations of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the practice may release objective clinical information related to my diagnosis and treatment which may be requested by my insurance company or its designated agent.

_____
(initials)

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GAURANTEE: I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for any covered or non-covered services as defined by my insurer. This includes all co payments, coinsurances and deductibles.

_____
(initials)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE: I acknowledge that Hosey Foot and Ankle Centers has provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity if I so choose) and understand the Notice.

_____
(initials)

AUTHORIZATION OF MEDICATION HISTORY: I authorize Hosey Foot and Ankle Centers to review my medication history from pharmacies.

_____
(initials)

AUTHORIZATION FOR CONFIDENTIAL COMMUNICATIONS: Authorization to those that I give permission to ask questions and speak on my behalf regarding my medical care & treatment is (example: family, friends and significant other): Name/s:

_____
_____
_____

I permit a scanned copy of this authorization to be used in place of the original for my electronic chart.

Patient or Authorized Person Signature _____
Relationship _____ Date_____