Welcome To Our Office

www.alaskapodiatry.com

Last Name: ______________________ **First Name:** ______________________ **MI:** __________

Mailing Address: ____

City: ______________________ State: __________ Zip Code: ____________

Home Phone: ____________ Cell Phone: ______________ Work Phone: ____________

Date of Birth: ________________ Age: ________ SSN#: ____________________

Gender: [ ] Male [ ] Female Marital Status: [ ] S [ ] M [ ] W [ ] D Referred By: ____________________

Occupation: ____

If Patient is a Minor, Parent or Legal Guardian Name: ______________________________

Employer: ________________ Date of Birth: ____________ SSN#: ____________

Home Phone: ____________ Cell Phone: ______________ Work Phone: ____________

Emergency Contact: (Last, First, MI) ______________________________

Home Phone: ____________ Cell Phone: ______________ Work Phone: ____________

Primary Insurance Company: ______________________ ID #: ____________________

Name of Insured: ________________________ Date of Birth: ________________

Secondary Insurance Company: ______________________ ID #: ____________________

Name of Insured: ________________________ Date of Birth: ________________

Is there anyone we can speak to regarding this account? [ ] Billing [ ] Medical [ ] Scheduling

Name: ____________________ Relationship: ____________ Date of Birth: __________

Name: ____________________ Relationship: ____________ Date of Birth: __________

Financial Responsibility and Assignment of Benefits: I herby acknowledge and understand that I am financially responsible for all charges incurred on my (or my dependent's) behalf whether or not paid by insurance. I authorize the use of this signature on all insurance submissions and that my insurance benefits are paid directly to my doctor. I understand that it is the policy of this office for accounts outstanding over 90 days is turned over to collections unless other arrangements are made. In the event that my account is sent to collections, I acknowledge responsibility for any additional costs incurred. I also certify that I have declared all insurance coverage to this office.

______________________________ ______________________

Signature of Patient or Patient's Legal Representative **Date**

Medical History

Patient Name: (Last, First, MI) ____

Date of Birth: ______________________________

Referring Physician: (If Applicable) ____

What is the chief complaint for which you came to be treated? ____

____

____

Cigarette/Tobacco use? [ ] Yes [ ] No Number of years: _____________________ Times per day: ____________________

Do you drink alcohol? [ ] None [ ] Daily [ ] Weekly [ ] Monthly

Check no or yes below to indicate if YOU have/had any of the following conditions:

Aids/HIV	[ ] No [ ] Yes	Anemia	[ ] No [ ] Yes	Arthritis	[ ] No [ ] Yes
Back Problems	[ ] No [ ] Yes	Blood/Bleeding Disorders	[ ] No [ ] Yes	Cancer	[ ] No [ ] Yes
Chemical/Drug Dependent	[ ] No [ ] Yes	Circulatory Problems	[ ] No [ ] Yes	Radiation or Chemo	[ ] No [ ] Yes
Diabetes	[ ] No [ ] Yes	Ear Problems	[ ] No [ ] Yes	Varicose Veins	[ ] No [ ] Yes
Eye Problems	[ ] No [ ] Yes	Fainting	[ ] No [ ] Yes	Foot or Leg Cramps	[ ] No [ ] Yes
Gout	[ ] No [ ] Yes	Headaches	[ ] No [ ] Yes	Heart Disease	[ ] No [ ] Yes
High Blood Pressure	[ ] No [ ] Yes	Hormone Disorder/Thyroid	[ ] No [ ] Yes	Implants Prosthetics	[ ] No [ ] Yes
Stroke	[ ] No [ ] Yes	Kidney Problems	[ ] No [ ] Yes	Liver Disease	[ ] No [ ] Yes
Low Blood Pressure	[ ] No [ ] Yes	Infections	[ ] No [ ] Yes	Hepatitis or Jaundice	[ ] No [ ] Yes
Phlebitis/Blood Clots	[ ] No [ ] Yes	Swelling in Ankles or Feet	[ ] No [ ] Yes	Ulcers	[ ] No [ ] Yes
Rheumatic Fever	[ ] No [ ] Yes	Shortness of Breath	[ ] No [ ] Yes	Venereal Disease	[ ] No [ ] Yes

Please list other illnesses that you are suffering from: ____

____

Please list any hospitalization or surgeries in the last 5 years: ____

____

Women: Are you pregnant now? [ ] No [ ] Yes
Do you anticipate becoming pregnant? [ ] No [ ] Yes

Please list all medications that you are currently taking, including prescriptions, over-the-counter medications and vitamins:

____

____

Please check all items you are currently allergic to: [ ] NO KNOWN DRUG ALLERGIES
[ ] Adhesive/Tape [ ] Anticoagulant Therapy [ ] Aspirin [ ] Codeine [ ] Demerol [ ] Iodine
[ ] Local Anesthetics [ ] Novocain [ ] Penicillin [ ] Seafood [ ] Sulfa
[ ] Other ____

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as deemed necessary in the diagnosis and/or treatment. I accept financial responsibility for all charges incurred.

____ ______________________________

Signature of Patient or Patient's Legal Representative **Date**

PATIENT FINANCIAL POLICY

Thank you for choosing Alliance Foot and Ankle. We understand that many patients find financial matters surrounding their medical care to be very complex and often confusing. If you ever have a question regarding our billing policies, we will be happy to assist you.

Private Health Insurance: Initial Here ______	We are ***ONLY*** contracted, labeled "preferred" or considered In-Network with Blue Cross Blue Shield plans. As the patient, you are responsible for requesting prior approval and/or benefit level exceptions from your insurance if required. Our office collects any co-pay or deductible amount at the time of service. You will be balance billed for any amount not considered by your plan in addition to your deductible, co-pay and/or co-insurance amounts not collected at the time of service.
Medicare: Initial Here ______	We are a contracted provider with Medicare. You must be enrolled in Medicare Part B to be eligible for benefits. We will bill you for any remaining deductible, co-insurance and/or patient notified non-covered services after Medicare processes.
Medicaid/Denali Kid Care: Initial Here ______	We are a contracted provider with Medicare/Denali Kid Care. Please note our office does NOT accept CAMA or Disability Exam benefits. A referral is required if you are in the Lock-In Program, without a referral you will be considered a self-pay. Anyone over the age of 21 is not eligible for podiatry services unless they have Medicare Part B.
Tricare/Veterans Administration: Initial Here ______	We are a network provider with Tricare and Veterans Administration. *Active duty Service Members and Dependents are required to have a referral from your Primary Care Manager and authorization before treatment.* Tricare standard beneficiaries have a fee-for-service option with no referral requirements. Tricare for Life claims are electronically forwarded by Medicare. We will bill the VA for your prior authorized treatments. Referrals and authorizations are never a guarantee of payment.
Workers Compensation: Initial Here ______	We only accept Workers' Compensation claims that were filed with the Alaska Department of Labor. Your claim must be open and accepted. You must provide your carriers information including claim number and date of injury. No payment is required at the time of service. Please note we do NOT accept Federal or Out of State Workers' Compensation.
Auto Accident: Initial Here ______	A claim must be established with your auto insurance carrier. We will only bill first party claims (your auto insurance policy) regardless of fault. Once your medical benefits are exhausted your private insurance may be billed. YOU MUST CONTACT YOUR PRIVATE INSURANCE TO DISCLOSE YOUR LIABILITY CLAIM. If you have no other insurance coverage, your account will be transferred to a self-pay status and payment will be due upon receipt unless other billing arrangements have been approved by the Office Manager.
Self Pay/Un-Insured: Initial Here ______	Payment is due in full at the time of service unless other billing arrangements have been approved by the Office Manager.
Payment Plans: Initial Here ______	Payment plans are based on a case by case ***ONLY*** and must be approved by the Office Manager. Please note our payment plans are based on a maximum number of months from the date of services are rendered. Once you have reached the maximum length of the payment plan you must obtain alternative financing. All payments are applied toward your oldest services first.
Durable Medical Equipment: Initial Here ______	We require payment in full at the time of service for durable medical equipment, as your insurance company may not cover these items, regardless of insurance. We no longer bill any insurance company for over the counter medications purchased in the office.
Returns: Initial Here ______	All over the counter products that are new and unused with original packaging can ***ONLY*** be returned if within 30 days of purchase date.
Refunds: Initial Here ______	We only send refund checks if the credit is $30.00 or more. We will hold the credit under $30.00 on file unless you call and request the credit be refunded to you. We charge a $3.00 fee for postage and handling on all refunds.

- I have read, understand and agree to the Financial Policy.
- I understand that I am ultimately responsible for my balance, not my insurance carrier.
- I authorize Alliance Foot and Ankle to release pertinent medical information to my insurance company when requested in order to facilitate payment.
- I understand that my signature authorizes benefits to be paid directly to Alliance Foot and Ankle
- I understand that if my account becomes delinquent after 90 days it may be referred to a collection agency.

I acknowledge that I had the opportunity to read or have a copy of the Notice of Privacy Practice if I chose and that I Understand the Notice.

____
Name of Patient

______________________________________ ________________________
Signature of Patient or Patient's Legal Representative **Date**

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AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION

Patient Name____

Patient Date of Birth___________________________

I hereby authorize Alliance Foot and Ankle to:

_____ Release Records To **_____ Obtain Records From**

Person/Agency: ____

Address: ____

City, State, Zip: ____

Phone #:____________________________ **Fax:**____________________________

Comments:____

____

____

____

____

____

Patient Signature and Date

Employee Initials___________