## **Welcome To Our Office**



www.alaskapodiatry.com

Last Name:	First Name:		MI:
Mailing Address:			
City:	State: _	Zip Code: _	
Home Phone: Cell Ph	one:	Work Phone:	
Date of Birth:	Age:	SSN#:	
Gender: [ ] Male [ ] Female Marital Status: [ ] S	[]M[]W[]D Referr	ed By:	
Occupation:			
If Patient is a Minor, Parent or Legal Guardian Na	me:		
Employer:	Date of Birth:	SSN#:	
Home Phone: Cell Ph	ione:	Work Phone:	
Emergency Contact: (Last, First, MI)			
Home Phone: Cell Ph	one:	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 ac		Medical [ ] Scheduling	
Name:	Relationship:	Date o	of Birth:
Name:	Relationship:	Date o	of Birth:
Financial Responsibility and Assignment of Benefits: I he on my (or my dependent's) behalf whether or not paid be insurance benefits are paid directly to my doctor. I under	y insurance. I authorize the	use of this signature on all insurance	ce submissions and that my

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.

## **Medical History**

Signature of Patient or Patient's Legal Representative



Patient Name: (Last, First, MI)					Foot & Ank	
Date of Birth:						
Referring Physician: (If Appl	icable)					
What is the chief complaint	for which you ca	me to be treated?				
Cigarette/Tobacco use? [ ]	Yes []No Nu	mber of years:		ר	Fimes per day:	
Do you drink alcohol? [ ] [	None [ ] Daily [	] Weekly [ ] Monthly				
Check no or yes below to in	dicate if YOU hav	e/had any of the follo	owing co	nditions:		
Aids/HIV Back Problems Chemical/Drug Dependent Diabetes Eye Problems Gout High Blood Pressure Stroke Low Blood Pressure Phlebitis/Blood Clots Rheumatic Fever  Please list other illnesses th			Fhyroid Feet			
	regnant now? ticipate becoming		o [ ] Yes o [ ] Yes			
Please list all medications th	hat you are curre	ntly taking, including	prescript	ions, over-the-	counter medications and	vitamins:
	re currently aller Anticoagulant Tl Novocain	nerapy [ ] As		I DRUG ALLERGI [ ] Codeine [ ] Seafood	[ ] Demerol	[ ] lodine
I certify that the above infor and perform such procedure incurred.						

Date

## PATIENT FINANCIAL POLICY



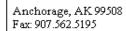
Thank you for choosing Alliance Foot and Ankle. We understand that many patients find financial matters surrounding their medical care to be very complex and often confusing. If you ever have a question regarding our billing policies, we will be happy to assist you.

Private Health Insurance: Initial Here	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:	We are a contracted provider with Medicare. You must be enrolled in Medicare Part B to be eligible for
Initial Here	benefits. We will bill you for any remaining deductible, co-insurance and/or patient notified non-covered services after Medicare processes.
Marking in / Days all Wind Comm	We are a contracted provider with Medicare/Denali Kid Care. Please note our office does NOT accept CAMA
Medicaid/Denali Kid Care:	or Disability Exam benefits. A referral is required if you are in the Lock-In Program, without a referral you will
Initial Here	be considered a self-pay. Anyone over the age of 21 is not eligible for podiatry services unless they have Medicare Part B.
	We are a network provider with Tricare and Veterans Administration. <u>Active duty Service Members and</u>
Tricare/Veterans	Dependents are required to have a referral from your Primary Care Manager and authorization before
Administration:	<u>treatment.</u> Tricare standard beneficiaries have a fee-for-service option with no referral requirements. Tricare
Initial Here	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.
	We only accept Workers' Compensation claims that were filed with the Alaska Department of Labor. Your
Workers Compensation:	claim must be open and accepted. You must provide your carriers information including claim number and
Initial Here	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:	Payment is due in full at the time of service unless other billing arrangements have been approved by the
Initial Here	Office Manager.
Payment Plans: Initial Here	Payment plans are based on a case by case <u>ONLY</u> 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:	We require payment in full at the time of service for durable medical equipment, as your insurance company
Initial Here	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:	All over the counter products that are new and unused with original packaging can <b>ONLY</b> be returned if within
Initial Here	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	





Patient Name		
Patient Date of Birth		_
I hereby authorize Alliance Foot and	l Ankle to:	
Release Records To		Obtain Records From
Person/Agency:		
Address:		
City, State, Zip:		
Phone #:	Fax:	
Comments:		
Patient Signature and Date		
Employee Initials		