Arizona Foot & Ankle Physicians
Phone: 480-247-8443 Fax: 480-292-9381

PATIENT INFORMATION

Patient Legal Name:_____Preferred Name:_____ Date of Birth: _____/_____/_____

Street Address: _____ City: _____ State: _____ Zipcode: _____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____ SSN: _____-_____-_____

E-mail Address: _____ Patient's Employer: _____

Sex: ☐ Male ☐ Female Patient's Ethnicity: _____ Preferred Language: _____

May we notify you via secure e-mail, text or voicemail regarding medical care, reminders, billing, or other matters? ☐ Yes ☐ No

Contact Preference: ☐ Cell Phone(Call) / ☐ Text Message / ☐ Patient Portal / ☐ Email / ☐ Home Phone

Emergency Contact:_____ Phone:_____ Relationship:_____

I authorize Arizona Foot and Ankle Physicians to obtain my past medical & RX history ☐ Yes ☐ No / Referred by: _____

How did you hear about our office?_____

Primary Care Physician:_____ Office #: (_____)_____-_____ Fax #: (_____)_____-_____

Pharmacy: _____ Phone #: _____ Cross Streets: _____

1) Is today's visit due to an injury at work? Please check ☐ Yes or ☐ No
2) If yes, have you notified your HR department? ☐ Yes or ☐ No
3) If work related, please provide a brief description of the injury :

_____

INSURANCE INFORMATION

Patient is: ☐ Subscriber ☐ Spouse ☐ Dependent | **Name of Insured**:_____

Primary Insurance: _____ ID/Member#:_____ Insured's DOB:___/___/___

Secondary Insurance: _____ ID/Member#:_____ Insured's DOB:___/___/___

MISCELLANEOUS

The office has provided me with a copy of the Privacy Policy and/or an opportunity to view the Privacy Policy (Page 4 & also viewable online) and **I authorize the below list of person(s)** to receive my Protected Health Information. I understand that I may revoke this at any time by giving written notification to the provider.

_____

_____

☐ I have a medical power of attorney and would like to provide a copy for my medical record to the office.

Patient's Signature:_____ Date:_____

Patient's Authorized Representative Signature(if necessary):_____

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MEDICAL INFORMATION

What is the chief complaint(s) that brings you to our office for medical treatment?_____

_____

Have you been previously treated by a Podiatrist? _____ When? _____Treated for?: _____

Symptoms of Current Problem: **Which Side:** ☐ Right ☐ Left ☐ Both

Type of Pain: ☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Burning ☐ Shooting ☐ No Pain

Area of Pain: ☐ Bottom of Heel ☐ Back of Heel ☐ Arch ☐ Ball of Foot ☐ Big Toe ☐ Top of Foot

☐ Ankle ☐ Other/Details:_____

How long has this problem been bothering you?_____

Has the pain gotten: ☐ Better ☐ Worse ☐ Stayed the Same **Severity**: ☐ Mild ☐ Moderate ☐ Severe

Please list ALL Medications and dosage

_____
_____
_____
_____

Please list all ALLERGIES you have:

_____
_____
_____
_____

FAMILY/MEDICAL HISTORY

If you OR a family member have or ever has had any of the following conditions please check (X). If family, please specify relationship to the right.

Self	Family		Self	Family		Self	Family	
☐	☐	Arthritis	☐	☐	Circulatory Problems	☐	☐	HIV Positive
☐	☐	Anemia	☐	☐	Diabetes	☐	☐	Kidney Problems
☐	☐	Artificial Heart	☐	☐	Epilepsy	☐	☐	Liver Disease
☐	☐	Asthma	☐	☐	Fibromyalgia	☐	☐	Lung Problems
☐	☐	Back Problems	☐	☐	Gout	☐	☐	Mental Illness
☐	☐	Bleed Easily	☐	☐	Heart Disease	☐	☐	STD
☐	☐	Cancer	☐	☐	Hemophilia	☐	☐	Stroke
☐	☐	Chemical Dependency	☐	☐	Hepatitis	☐	☐	Thyroid Problems
☐	☐	Chest Pain	☐	☐	High Blood Pressure	☐	☐	Ulcers - Stomach

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FAMILY/MEDICAL CONT.

Current Smoker? _____ Former Smoker? _____ Year quit? _____ How Often? _____

Do you drink alcohol? _____ How Often? _____ Recreational Drugs? _____ Which? _____

Please list all major surgeries, illnesses or injuries:

_____

_____

Are you pregnant, possibly pregnant? ☐ Yes ☐ No

Patient's Signature: _____ **Date:**_____

CONSENT FOR TREATMENT

I, and/or my representative, recognize the need for medical care. I, and/or my representative, consent to all or any services as ordered by Dr. Kosak. Including, but not limited to, examination, laboratory tests, radiographs, medical or surgical treatment, and any other services rendered under her specific instructions.

Payment Policy

It is our pleasure to serve as your health care provider. Please read this policy carefully and ask any questions you may have, then sign in the space provided. A copy will be provided to you upon request.

- **Insurance:** We participate in many insurance plans. If you are not insured by a plan we are contracted with, payment in full is expected at each visit. If you are insured by a plan we are contracted with, but do not have an up-to-date insurance card, payment in full is required for each visit until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions regarding coverage.
- **Co-Payments and Deductibles**: All co-payments and deductibles must be paid at the time of service.
- **Non-Covered Services**: Please be aware that any service considered to be a non-covered benefit by your insurance will be your financial responsibility.
- **Proof of Insurance:** We must obtain a copy of your current insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
- **Claim Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.
- **Non-payment:** Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice.
- **Missed and Late Appointment Policy:** Our office has a 24 business hour cancellation policy, otherwise there may be a $25 fee billed directly to you. Please help us serve you better by keeping your scheduled appointments, or calling ahead of time to cancel.

I have read and understand the payment policy and agree to abide by its guidelines.

Patient's Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES:

Arizona Foot and Ankle Physicians, PLLC is required to:

1. Maintain the privacy of your health information at all times.
2. Provide you with this notice as to what our legal duties and privacy practices are with respect to information we collect from you as a patient.
3. Abide by the terms of this practice.
4. Notify you if we are not able to agree to your requested restriction, and accommodate any reasonable request you may have to communicate health alternative means or alternative locations.
5. We will not use or disclose your health information without your authorization, except as described in this notice.
6. We will use and disclose your Protected Health Information(PHI) in order to bill and collect payment for services and items you may have received from us. We will contact your insurance to verify that you are eligible for benefits and we may provide your insurance with details regarding your treatment to determine coverage.

We are permitted to use and may be required to disclose your PHI under special circumstances:

1. Disclosure required by law. When we are required to do so by federal, state, or local law, including health oversight activities, court or administrative orders or similar legal proceedings.
2. Public Health Risk: To public health authorities who are authorized to collect information notifying a person regarding potential exposure to communicable disease.
3. Serious Threats to Health or Safety: When necessary to reduce or prevent a serious threat to your health and safety, the health and safety to another individual or to the public.
4. Deceased Patients: To a medical examiner or coroner to identify a deceased individual or to identify the cause of death. Also, to funeral directors, if necessary.
5. Organ Donor: To a medical facility or organ donation bank for tissue procurement or transplantation.
6. Worker's Compensation: For workers' compensation and similar programs as requested by patient.

Our practice may contact you or your authorized representative.

I have read and understand Arizona Foot and Ankle Physicians Privacy Policy.

Patient's Signature: _____ Date:_____

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FINANCIAL POLICY

Please read and initial that you have read all of the following statements listed below:

All patients are responsible for payment at time of service, unless prior arrangements have been made.

WE ACCEPT: _____
Cash, Check, Debit Cards, MasterCard, Visa, Discover & American Express.

INSURANCE AND CO-PAYMENTS: _____
Insurance Co-pays are collected at the time of service.

DEDUCTIBLE/CO-PAYMENTS: _____
If your insurance deducible is not met, full payment will be collected at the time of service.
If your deducible is met, your co-insurance amount will be collected at the time of service.

PRIVATE PAY: _____
If you have no insurance coverage or insurance that we do not participate with
full payment is expected at the time of service.

HMO INSURANCE: _____
Authorization is required in our office on the date of service.
If we have not received your authorization, your options are:

1. Reschedule appointment
2. Accept charges as your responsibility and pay services in full.

DISABILITY RELATED DOCUMENTS FILLED OUT BY PHYSICIAN: _____
A fee of $40.00 will be charged to complete documentation by the physician outside of normal medical charting.

RETURNS: _____
Due to the unique nature of custom made items (foot orthotics, braces, etc), no refunds can be given.

COLLECTIONS: _____
Once an account is placed in collection, all future services must be paid in full at the time of service.
Any balance assigned to collections will be assessed a 35% fee for recovery expense.

MISSED APPOINTMENTS: _____
Patients who fail to show up to their scheduled appointment and do not notify the office within
24 hours prior to their scheduled appointment may be charged a $25.00 No-Show fee.

MEDICAL RECORDS: _____
Arizona Foot and Ankle Physicians will provide you, upon written request OR signed medical release form, a paper copy of your medical record. Arizona Foot and Ankle Physicians will charge a base fee of $10 plus $0.10 per page. This fee applies to copies of medical progress notes, laboratory requests, and other medical reports obtained at a time other than an office visit. Once you are in possession of your own medical records, Arizona Foot and Ankle Physicians is not responsible for the dissemination of that information. It is your responsibility to ensure that they reach their destination.

It is also your responsibility to notify us of any changes to address or insurance coverage. We do not call to obtain authorization for services. It is your responsibility to contact your plan for clarification of benefits prior to being treated. It is your responsibility to make sure we are in network with your insurance plan. Please sign and date below to show you agree with the above information.

Signature:_____ Date:_____