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

PATIENT INFORMATION

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

Street Address: _____

City: _____ State: _____ Zipcode: _____

Contact Phone: (_____)_____-_____ SSN: _____-_____-_____

E-mail Address: _____ Sex: Male ☐ Female ☐

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

Emergency Contact:_____ Phone:_____ Relationship:_____

I authorize Arizona Foot and Ankle Physicians to obtain my past medical & RX history Yes ☐ No ☐

How did you hear about our office?_____

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

Pharmacy: _____ Phone #: _____ Cross Streets: _____

I wish to release any and all medical records to the following individuals, and I understand that I may revoke this authorization at any time:

_____

_____

_____

Patient Signature: _____ Date:_____

Guardian Signature:_____ Date:_____
(If applicable)

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MEDICAL INFORMATION

Reason for visit? _____

_____

Which Side: Right ☐ Left ☐ Previously treated by a Podiatrist? _____ Shoe Size: _____

Please list ALL Medications and dosage

_____
_____
_____
_____
_____

Please list all ALLERGIES you have:

_____
_____
_____
_____
_____

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	___	___ Hemophilia
___	___ Cancer	___	___ Stroke	___	___ Thyroid Problems
___	___ Chest Pain	___	___ High Blood Pressure	___	___ Ulcers - Stomach

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

Do you drink alcohol? _____ How Often? _____Are you pregnant, possibly pregnant? ____ Yes ____ No

Please list all major surgeries, illnesses or injuries:

_____
_____
_____
_____

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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**: 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 may be discharged from this practice. Any balance assigned to collections may assess a 35% fee for recovery expense.
- **Returns**: Due to the nature of custom made items (foot orthotics, braces, etc.), no refunds can be given.

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.

NOTICE OF PRIVACY PRACTICES:

Arizona Foot and Ankle Physicians, PLLC is required to:

Maintain the privacy of your health information at all times. 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. Abide by the terms of this practice. 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. We will not use or disclose your health information without your authorization, except as described in this notice. 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:
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. Public Health Risk: To public health authorities who are authorized to collect information notifying a person regarding potential exposure to communicable disease. 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. 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. Organ Donor: To a medical facility or organ donation bank for tissue procurement or transplantation. Worker's Compensation: For workers' compensation and similar programs as requested by patient.

I have read, understand and agree to all of Arizona Foot and Ankle Physician's policies.

Patient Signature:_____ Date:_____

Guardian Signature: _____ Date:_____

We are grateful for the trust you have placed in our hands, and for the opportunity to serve our patients and community.
We exist solely to heal others, and improve the quality-of-life of those under our care. If you have any questions, comments, or suggestions that may help us reach more patients, please call the office at (480) 247-8443 and ask for Patrick, or e-mail us anytime at podiatryoffice@drkosak.com.