South County Foot & Ankle, Inc

Medicine and Surgery of the Foot and Ankle

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Would you like access to your personal health information online? ◯ YES ◯ NO Email: _____

Do you have an Advance Directive (details of medical care wishes if incapacitated)? ◯YES ◯NO

Marital Status: _____ DOB: _____ Age: _____ ◯ Male ◯ Female

Height: _____ Weight: _____ Shoe Size: _____

Employer: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

May we talk to this person regarding your medical concerns if we cannot reach you? ◯YES ◯ NO

May we leave a message at your home or cell phone regarding appointments? ◯ YES ◯ NO

Primary Care Doctor: _____Date last seen: _____

Primary Care Address: _____

Preferred Pharmacy: _____

Whom may we thank for referring you? _____

Primary Insurance: _____

Additional Insurance: _____

Agreement and Release: I, the undersigned, certify that I (or my dependent) have current insurance coverage with the above carriers and assign directly to South County Foot and Ankle, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize South County Foot and Ankle, Inc to administer such treatments and perform such procedures necessary or advisable in the diagnosis and treatment of the undersigned or designated patient. I have received my HIPAA (Health Insurance Portability and Accountability) Privacy Notice and understand my rights.

_____

Responsible Party Signature Relation Date

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Briefly describe your foot problem(s): _____

_____

Please check all the following that you **currently have** or **ever had**:

	Yes	No		Yes	No		Yes	No
Diabetes			Anemia			Rheumatic Fever		
Heart Disease			Phlebitis			Rheumatoid Arthritis		
High Blood Pressure			Hepatitis			Gout		
Stroke			Asthma			Epilepsy		
Glaucoma			AIDS/HIV			Thyroid Problems		
Kidney Disease			GI Ulcer			Liver Disease		
Bleeding			Cancer			Heart Murmur		

Other Medical Problems (please list here)

FAMILY HISTORY	Y	N
Diabetes		
High Blood Pressure		
Heart Disease		
Circulation Problems		

Past surgeries and hospitalizations: _____

_____

Have you fallen in the last year? ◯YES ◯NO How many? _____

If YES, any injuries? ◯YES ◯NO

Medications:_____

_____

_____

_____

Allergies to Medications: _____

Latex: ◯ YES ◯ NO Medical Tape: ◯ YES ◯ NO Contrast Dye: ◯ YES ◯ NO

Please check all that apply:

Smoke? ◯ Y ◯ N How many packs per day? _____ Years? _____

Drink? ◯ Y ◯ N How many drinks per day? _____ Years? _____

Drug Use? ◯ Y ◯ N If yes, what type? _____

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PATIENT FINANCIAL AGREEMENT

Our staff is happy to work with you to help answer any questions you may have about the services we offer and how payment is handled. Please note, however, that some issues can only be addressed between you and your insurance provider(s). This document explains some common responsibilities you may have as a patient; please take a moment to review it and let us know if you have any questions or comments.

Patient Responsibilities

1. You are responsible for providing us with accurate billing information for each family member at the time of service.
2. If your insurance company requires you to choose a Primary Care Physician (PCP), it is your responsibility prior to your visit to update your insurance information with your specific insurance company.
3. Our billing staff is available to provide you with assistance but cannot resolve disputes between you and your insurance company.
4. If your insurance company requires a referral, you must obtain this from your Primary Care Physician before your visit to our office.

Copayments

1. Your insurance company requires you to pay your copay at the time of each visit.
2. Your copay may be made with cash, check, credit/debit card.
3. If your check is returned, a $25.00 returned check fee will be assessed. After 2 subsequent returned checks, you will be required to pay by cash or with credit card only.
4. If you do not have insurance coverage at the time of your visit, you will be considered a “self-pay” patient with payment due at the time of service.
5. Our billing department will send out billing statements for outstanding balances. If your balance is unpaid after two billing cycles, your account will be automatically sent to a collection agency. It is the policy of our collection agency to report delinquent accounts to credit bureaus.

Deductibles

1. It is your responsibility to understand any deductibles that may apply to you under your insurance policy.
2. Our billing department will send you a statement of the amount your insurance company has determined is applied to your deductible and is owed by you.

Insurance Information

1. It is your responsibility to ensure that we have accurate insurance information. If an insurance claim is rejected because of incorrect information provided by you, you are responsible for full payment.
2. South County Foot and Ankle will submit claims to your insurance carrier on your behalf. You give us permission to provide your insurer(s) with any information necessary for payment. You give us permission to ask your insurer(s) to pay us directly for the care we provide.
3. If you have multiple insurance policies, you must inform us of each policy. It is your responsibility to know which insurer is primary and to inform us of this.

4. Medical insurance DOES NOT always cover the entire cost of your medical care. If we provide a service and we are not expecting your insurance to cover the claim, we will tell you. In some instances, however, we do not learn that a service is not covered until after we submit a bill.

Durable Medical Goods

1. These include but are not limited to:
    a. Night Splints
    b. Braces
    c. Shoe Inserts
    d. Orthotics
    e. Air Braces
    f. Diabetic Shoes
    g. Ankle Supports
2. These goods may not be covered either partially or in full by your carrier. In the event these goods are not covered, you will be expected to pay the balance at the time of visit or immediately upon receipt of billing.

Home Address and Telephone Number

1. You will be asked to complete a patient registration form that asks for important information about you. Please complete this form to the best of your knowledge and keep us informed of any changes on subsequent visits.
2. It is important that we have accurate information on the guarantor. This is the person financially responsible for your bills.

Special Circumstances

1. We may accommodate special arrangements for payments in extenuating circumstances upon request. Please note that this is at our discretion. If special arrangements are made for divided payment, prompt reimbursement will be expected on the arranged schedule. Missed payments will be handled as any other delinquent payment as described above.

PLEASE SIGN BELOW TO SIGNIFY THAT YOU UNDERSTAND THE INFORMATION CONTAINED IN THIS FINANCIAL AGREEMENT.

Signature: _____ Date: _____

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MISSED APPOINTMENT POLICY

We want to thank you for choosing us as your health care provider. To give you and all our patients the best possible care, we request that you review our policy regarding missed appointments. A missed appointment is when you fail to show up for an allotted appointment time without a phone call or cancellation notice of at least 24 hours. Please remember that we have reserved an appointment time especially for you. Therefore, we request a 24-hour notice to reschedule your appointment. This will enable us to offer your cancelled time to other patients.

If you are unable to keep your scheduled appointment time, please call our office at least 24 hours in advance to avoid a missed appointment fee. This charge is not covered by insurance. Your phone call is critical in helping to provide timely care for all our valued patients. If you fail to give us notice of your missed appointment, you will be charged a $25 missed appointment fee.

INSURANCE INFORMATION

Please be aware that there are some very important changes happening with most insurance companies and our office that may affect your ability to be seen and/or have your claim paid.

Blue Cross Blue Shield

BCBS requires a referral through your PCP for all non-PPO plans and Medicare Advantage Plans. Your PCP must go through BCBS to obtain the referral and fax it to our office.

United Health Care

UHC has waived all insurance referrals for Community Plan and AARP members since the COVID 19 pandemic began in 2020. Please confirm with the insurance company about your specific plan before making an appointment.

Medicare

Medicare sent out updated cards in 2018. You must present the new card at your first appointment. Medicare also requires you to be seen by your PCP within 6 months of your visit to our office to receive routine foot care.

Tufts

Tufts requires a referral for ALL VISITS.

Please note: It is your responsibility to contact your PCP for these referrals prior to your visit. If a referral is required by your insurance company and we do not have one on file, you may be charged for the visit. If you have any questions regarding these policies, please ask the front desk.

Signature: _____ Date: _____