

# NORTH STAR FOOT & ANKLE ASSOCIATES, P.A.

## PATIENT INFORMATION

Last Name: \_\_\_\_\_ MI: \_\_\_\_\_ First Name: \_\_\_\_\_  
Physical Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Alternate/Billing Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Best time/place to reach you: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Employer Name/Address: \_\_\_\_\_ Student: Yes/No

## PRIMARY INSURANCE

Insurance Name: \_\_\_\_\_ If required did you bring your referral: Yes/No  
Insurance Phone #: \_\_\_\_\_ Claims address: \_\_\_\_\_  
Policy/Member ID: \_\_\_\_\_ Group/Account #: \_\_\_\_\_  
Primary Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ SSN: \_\_\_\_\_  
Primary Insured's home address: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_

## SECONDARY INSURANCE (If applies)

Insurance Name: \_\_\_\_\_ If required did you bring your referral: Yes/No  
Insurance Phone #: \_\_\_\_\_ Claims address: \_\_\_\_\_  
Policy/Member ID: \_\_\_\_\_ Group/Account #: \_\_\_\_\_  
Primary Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ SSN: \_\_\_\_\_  
Primary Insured's home address: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_

## RELEASE OF INFORMATION

For the purpose of payment, I allow North Star Foot and Ankle Associates, P.A. to release my Private Health Information to any and all of my insurance carriers, their third party payors and claim reviewers, until the claim is resolved. For the purpose of treatment, I also allow the above listed practice to release my information or contact any and all of my treating physicians.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# NORTH STAR FOOT & ANKLE ASSOCIATES, P.A.

## PATIENT FINANCIAL POLICY (Please initial each line and sign below)

\_\_\_\_As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. You must inform the office of all personal and/or insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

\_\_\_\_Your portion of payment for office services are due **at the time of service**.

\_\_\_\_Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you, and you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, the patient or guardian seeking care for a minor, will be responsible for payment of services.

\_\_\_\_Please honor our 24 reschedule notice, as there is a charge for broken appointments. Repetitive broken or cancelled appointments and/or non-compliance may result in transfer of your care to an alternative practice.

\_\_\_\_We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will require you to pay the co-pay/co-insurance/deductible at the time of service. Your upfront portion will be calculated based on your insurance benefit/limits and our negotiated fee agreement with your carrier. If you are seeing our doctors on an "Out of Network" basis, you will be subject to those out of network rates.

\_\_\_\_Not all services are a "covered" benefit in all insurance policies. Some plans even impose a waiting period before covering services. In the event your health plan determines a service to be "not covered/pre-existing," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

\_\_\_\_Pre-scheduled Surgical procedures require pre-payment. Your deductible/co-insurance/co-pay for this procedure is due at the pre-operative appointment. For other services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

\_\_\_\_We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account.

\_\_\_\_PAST DUE accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

\_\_\_\_There is a service fee of \$25.00 for all returned checks. Upon an NSF or CLOSED ACCOUNT occurrence, all future remittances will need to be in other forms of payment. Restitution of "Theft-by-Check" will be requested from the District Attorney's Office.

## AUTHORIZATION OF PAYMENT

\_\_\_\_I hereby assign all Medical benefits directly to North Star Foot and Ankle Associates for the payment of any services rendered. I also authorized release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay for the services I received, I will be financially responsible for payment.

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff.

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

\_\_\_\_I acknowledge that I was provided a copy of the HIPPA Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient's Name: \_\_\_\_\_ Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Witness: \_\_\_\_\_ Date: \_\_\_\_\_

# NORTH STAR FOOT & ANKLE ASSOCIATES, P.A.

## GENERAL HISTORY:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_ Feet \_\_\_\_ Inches Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_ Occupation: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Date last seen: \_\_\_\_\_ Phone: \_\_\_\_\_

Current foot/ankle problem: \_\_\_\_\_

\_\_\_\_\_

When did the problem start? \_\_\_\_\_

What has been done to treat the problem? \_\_\_\_\_

Name of former Podiatrist: \_\_\_\_\_ Location: \_\_\_\_\_

Have you ever worn orthotics/arch supports?  Yes  No. If yes, what kind: \_\_\_\_\_

## MEDICAL HISTORY: (Please check any that apply to **YOUR** health)

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV                | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Depression           | <input type="checkbox"/> Hyperthyroidism     | <input type="checkbox"/> Reflux              |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Diabetes Type _____  | <input type="checkbox"/> Hypothyroidism      | <input type="checkbox"/> Respiratory disease |
| <input type="checkbox"/> Angina                  | <input type="checkbox"/> Dialysis             | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Rheumatic fever     |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Ear problems         | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> Sinus problems      |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Liver disease       | <input type="checkbox"/> Skin cancer         |
| <input type="checkbox"/> Artificial joints       | <input type="checkbox"/> Eye problems         | <input type="checkbox"/> Low blood pressure  | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Lupus               | <input type="checkbox"/> Swollen glands      |
| <input type="checkbox"/> Back problems           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Neuropathy          | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Bleeding disorders      | <input type="checkbox"/> Gout                 | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> Bronchitis              | <input type="checkbox"/> Heart attack         | <input type="checkbox"/> Phlebitis           | <input type="checkbox"/> Varicose veins      |
| <input type="checkbox"/> Cancer _____            | <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Venereal disease    |
| <input type="checkbox"/> Cataracts               | <input type="checkbox"/> Heart surgery        | <input type="checkbox"/> Prostate problems   | <input type="checkbox"/> _____               |
| <input type="checkbox"/> Chemical dependency     | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Psoriasis           | <input type="checkbox"/> _____               |
| <input type="checkbox"/> Chronic diarrhea        | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Psychiatric care    | <input type="checkbox"/> _____               |

## SURGERIES AND HOSPITALIZATIONS: (Procedure and Year)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## MEDICATIONS: (Please list all prescriptions, over the counter, herbs, vitamins, and oral contraceptives)

1) \_\_\_\_\_ 5) \_\_\_\_\_

2) \_\_\_\_\_ 6) \_\_\_\_\_

3) \_\_\_\_\_ 7) \_\_\_\_\_

4) \_\_\_\_\_ 8) \_\_\_\_\_

Pharmacy name: \_\_\_\_\_ Phone: \_\_\_\_\_

## ALLERGIES: (Medications, foods, anesthetics, tape, latex, iodine, etc) or No Known Drug Allergies

1) \_\_\_\_\_ 3) \_\_\_\_\_

2) \_\_\_\_\_ 4) \_\_\_\_\_

# NORTH STAR FOOT & ANKLE ASSOCIATES, P.A.

## SOCIAL HISTORY:

Smoking: Never Rarely Moderately Daily Quit

Caffeine: None Rarely Moderately Daily Quit

Alcohol: None Rarely Moderately Daily Quit

Drug Use: None Rarely Moderately Daily Quit

If you are female, is there any chance you may be pregnant? Yes No

Athletic activities: \_\_\_\_\_ Frequency: \_\_\_\_\_

**FAMILY HISTORY:** (Please list any that applies to biological family) or Adopted Unknown

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Are you currently suffering from any of the following? (Please circle)

Fever Chills Night sweats Fatigue Rapid weight loss None

Rash Itching Changes in nails Skin discoloration Change in skin texture None

Bruising Bleeding Swollen ankles Cold feet Bluish hue to skin/nails None

Numbness Paralysis Poor balance Tremors Tingling/Pins/Needles None

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for referring you to our office?

Dr. \_\_\_\_\_ Friend \_\_\_\_\_ Insurance Website Advertisement Other \_\_\_\_\_

## TREATMENT AGREEMENT

I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

## CONSENT

I certify that the above and attached 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 may be deemed necessary for the diagnosis and/or treatment of me or my child's condition. As a representative of myself or as a guardian, I give authorization for the above listed patient to receive medical and/or surgical care and treatment with the physicians of North Star Foot and Ankle Associates, P.A.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_