FOOT & ANKLE INSTITUTE

PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of Foot & Ankle Institute/South Main Surgery Center not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to received information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you, anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check the line to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: _____yes ___no ___ Ph#_____

Parent: _____ yes ___no ___ Ph#_____

Other: _____yes __ no ___ Ph# _____

_____yes __ no ___ Ph# _____

_____yes __ no ___ Ph# _____

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you wish to be contacted by us in a certain way.

I hereby request the following means of contact only:

_____

_____

PRINTED NAME _____

Patient/Parent/Legal Guardian Signature: _____

Date: _____ (authorization good for 1 year from date of signed authorization)

***** Patient is responsible for any changes and or updates to this form. Notify office immediately for changes to take place to your "authorized to discuss account" record. *****

FOR OFFICE USE - Changes to above authorized by patient over phone

Change Date Staff Initials _____ date: _____

Patient Demographics Form

Chart No:_____

FOOT & ANKLE INSTITUTE

We appreciate your help in updating our records and acquiring any new information per government regulations.
ALL FIELDS DO REQUIRE COMPLETION

Name:_____ Preferred Name: _____Birth Date:_____

Local Address: _____
Street City State Zip code

Mailing Address: _____
(If different than above) City State Zip code

Preferred Phone # (_____) _____ (H) (C) Alternate Phone # (_____) _____(H) (C)
Indicate home/cell **indicate home/cell**

Email Address: _____ Female _____ Male _____

Social Security Number: _____-_____-_____ **HOW DID YOU HEAR ABOUT Foot & Ankle Institute?** _____

Name of Parent: **(if under age 18)** _____Phone# _____

Emergency Contact: _____-_____ Phone #_____
Name **relationship to patient**

Legal Guardian/Power of Attorney Yes ____ No _____ Name of legal guardian/POA _____
(Please provide copy of POA or legal guardianship documents)

Primary Care Physician: _____ Referring Physician: _____

Are you covered under medical insurance? **YES** **NO** **(circle the one that applies)**

>>>>IF NO - then payment in full is required at the time service is provided. <<<<<

>> ***IF YES - Foot & Ankle Institute will submit claims on your behalf when ALL information below is completed*** **<<**

Primary Insurance Company's name:
Primary member on insurance coverage: circle one that applies SELF SPOUSE PARENT
Name of the primary member:
Date of birth of that member:
Copy of insurance card must be provided

Secondary Insurance Company's name:
Primary member on insurance coverage: circle one that applies SELF SPOUSE PARENT
Name of primary member:
Date of birth of that member:
Copy of insurance card must be provided

If a Workers Comp claim was filed, please provide adjustor's name: _____
Contact Phone# _____ Claim number: _____
Employer: _____ Phone#: _____
IN ORDER TO FILE WORKERS COMP CLAIMS, AUTHORIZATION FROM THE ADJUSTOR'S OFFICE IS REQUIRED.
If not, health insurance coverage must be provided or cash payment in fill would be necessary. (a referral is not an authorization)

Employee: _____ **Date:** _____

See other side or next page

Patient's Name: _____ Chart # _____

CREDIT AND FINANCIAL CHARGE AGREEMENT

By signing below, I hereby authorize any benefits due to be paid directly to Foot & Ankle Institute and or South Main Surgery Center at 754 S. Main Street, Suite 3 St. George Utah 84770. I understand and agree that I am financially responsible for all deductible, co-insurance, co-pays, and non-covered service(s) or service(s) deemed as "non-medically necessary" by my benefit plan. I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that a late fee on all past-due balances until paid in full. In the event any amount(s) is/are referred to a third-party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principal amount(s) owing as allowed by state law, whether it be for the state of *Utah, Nevada, or Arizona*, based on location. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.
PROOF OF INSURANCE: ***All patients must complete our patient information form before seeing the doctor. You must provide valid and accurate insurance information in a timely manner, or you may be responsible for the balance of any claim(s) we file on your behalf.*** If payment is made it will be held and will become nonrefundable if the proper information is not provided within a reasonable time frame based on the member's insurance benefit carrier. If no insurance information is provided at time of service or no active benefits through medical coverage are available. I agree to pay the self-pay rate at the time service(s) is provided.
I also hereby expressly consent to receiving voice and or SMS (text) messages (including pre-recorded messages) on my mobile or any other telephone number(s) that I provide (either directly or through an intermediary) to Foot & Ankle Institute, LLC. I under and agree that such messages may be sent by Foot & Ankle Institute, may be sent via automated dialing technology (autodialed) and may consist of such things as appointment reminders and/or collection efforts.

PATIENT'S SIGNATURE_____DATE_____

PARENT or Legal Guardian's signature_____DATE_____

Medical Information Release

I acknowledge that I have been provided a copy of the NOTICE OF PRIVACY PRACTICES of Foot & Ankle Institute and that Foot & Ankle may release all or portions of my medical record to me, and to people or companies responsible to pay the charges for my care, such as my insurance or health benefits companies, or workers compensation carriers. I further acknowledge that Foot & Ankle Institute may disclose my patient information to referring or treating health care providers and for payment and health care operations. I hereby authorize Foot & Ankle Institute to obtain my medical information from other health care entities and providers, including but not limited to, copies of lab results, diagnosis test reports, films/images and other clinical information deemed necessary by Foot & Ankle Institute's physician's or representatives. I understand that I may inspect my protected heath information, request more information, and revoke this authorization, as permitted by the federal privacy regulations and in accordance with Foot & Ankle Institute's privacy policy.

PATIENT'S SIGNATURE: _____ DATE: _____

PARENT or Legal Guardian's signature_____ DATE: _____

Consent to Treat

I hereby consent to the medical treatment, diagnostic tests and other procedures, which Keith R. Reber, DPM and/or S. Kent Burton DPM and/or Lary J. Smith, DPM and/or Carl C. Van Gils, DPM and/or Andrew B. Powell, DPM and/or Leon K. Reber, DPM and/or Brad S. Webb, DPM and/or Ryan T. Peterson, DPM and/or Nisha Andersen, FNP-C and/or South Main Surgery Center may deem advisable in treatment of my podiatric care.

PATIENT'S SIGNATURE: _____ DATE: _____

PARENT or Legal Guardian's Signature: _____ DATE: _____

Medicare Patient Agreement **(for Medicare patient's only)**

Medicare member's Name_____ Medicare Subscriber Number _____
I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf to Foot & Ankle Institute and/or South Main Surgery Center for any services furnished to me by that provider. I authorize any holder of medical information and any information needed to determine these benefits or the benefits payable for related service about me to release this information to The Center for Medicare & Medicaid Services and its agents. This authorization is in effect until I choose to revoke this authorization in writing.

MEDICARE MEMBER'S SIGNATURE: _____ Date: _____

Patient's Name: _____ Chart# _____

PATIENT HISTORY

What is your foot problem? _____ Duration of problem: _____
If this is due to an injury, give date of injury, description and location of injury: _____
_____

Is this the first visit to a doctor for the problem? _____

ALLERGIES: **Are you allergic to any of the following:**

Adhesive ☐Yes ☐No	**Morphine ☐Yes ☐No**	**Latex ☐Yes ☐No**	**Iodine ☐Yes ☐No**
Aspirin ☐Yes ☐No	**Sulfa Drugs ☐Yes ☐No**	**Codeine ☐Yes ☐No**	**Penicillin ☐Yes ☐No**

Other, please list (can use back of page) _____

Height: _____ Weight: _____

DIABETES: **Are you Diabetic?** ☐ Yes ☐ No If so, what type? ☐ Type 1 ☐ Type 2 - Last A1c Value: _____
How do you manage your diabetes? ☐ Diet ☐ Insulin ☐ Oral Medication

Diabetic Physician's Name: _____ Phone# _____

SOCIAL HISTORY:
Do you Smoke? ☐Never ☐ Former ☐ Everyday
Do you Chew Tobacco? ☐ Never ☐ Former ☐ Everyday

IMMUNIZATIONS:
If over age 65, have you had a pneumonia vaccine?
☐ Yes ☐ No If yes, Date: _____

REVIEW OF SYSTEMS/MEDICAL HISTORY:
Please circle/check the conditions for which you have been or are currently being treated for:

Cardiovascular: o Rheumatic Fever o Murmur o Heart Attack o Angina o Congestive Heart Failure o Hypotension o Hypertension	**Respiratory:** o Asthma o Pneumonia o Short of Breath o Emphysema	**Neurologic:** o Weakness o Numbness o Strokes o Seizures o Migraines
Musculo-Skeletal: o Serious injuries or disorders of the Back o Deformities o Loss of Strength o Fibromyalgia o Joint Pains o History of Osteoarthritis or Rheumatoid arthritis	**Skin:** o History of MRSA o Lesions o Moles o Eczema o Rashes	**Gastrointestinal:** o Hepatitis o Liver Dysfunction o Ulcers o Hiatal Hernia o Reflux o Diverticulitis o Diarrhea
Endocrine: o Diabetes o Hypoglycemia o Thyroid Dysfunctions	**Hematologic:** o Anemia o Bleeding Tendencies	**Genitourinary:** o Bladder Problems o Prostate problem o ESRD, CRF, ARF o Renal Insufficiency o Receiving Dialysis

See other side or next page

Patient's Name: _____ Chart # _____

FAMILY HISTORY

Has anyone in your family (Mother, father, siblings, paternal/maternal grandparents, aunt, uncle etc.) had any of following? If so, who?

Arthritis: _____ Birth Defects: _____ Cancer (what Kind): _____

Diabetes: _____ Heart Attack: _____ High Blood Pressure: _____

Osteoporosis: _____ Stroke: _____

SURGICAL HISTORY: Please list or attach all surgeries you have had along with approximate dates:
Type of Surgery - Approx. Date (use back of page when necessary)

_____

_____

_____

Do you have any other condition or disease we should know about? _____

_____

_____

_____

CURRENT MEDICATIONS:

(Please complete as much of the following information as possible, use back if needed, OR *attach a list*)

Name	Strength	Dosage/Frequency

Preferred Pharmacy: _____ **Phone:** _____

Employee: Date: