NEW PATIENT INFORMATION

Patient Name: _____ Date of Birth: ____/____/_____
Last First Middle I.

Race: ☐ White
☐ Black/African American
☐ American Indian/Alaska Native
☐ Asian
☐ Native Hawaiian/Pacific Islander
☐ Other

Email Address:_____

Home #:_____ Cell #_____ Work#_____

Address: _____ City: _____ State: _____ Zip:_____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Pharmacy: _____

EMPLOYMENT STATUS:

1. Job Title/Occupation: _____

2. Employer_____

3. Please check current work status:

☐ Working Full Time ☐ Working Part Time ☐ Retired/Not Working ☐ Off Duty Due to Injury

FRANKEL Foot & Ankle

MEDICAL INFORMATION

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

Height: _____ (Verbal/Actual) Weight:_____ (Verbal/Actual)

PAST MEDICAL HISTORY:
History: Please check any applicable diseases/disorders. If these diseases/disorders run in your family, indicate below.

- **Heart disease:** ☐ Yourself ☐ Relative
- **Arthritis:** ☐ Yourself ☐ Relative
- **Hypertension:** ☐ Yourself ☐ Relative
- **Alcohol Abuse:** ☐ Yourself ☐ Relative
- **Diabetes:** ☐ Yourself ☐ Relative
- **Drug Abuse:** ☐ Yourself ☐ Relative
- **Cancer:** ☐ Yourself ☐ Relative
- **Other:** ☐ Yourself ☐ Relative

Current Medication

_____

_____

Allergies to Medications, Food, Other

_____

_____

Are you on a blood thinner? ☐ Yes ☐ No

Please List surgeries you have had:

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Social History:
Marital Status: Married: Name of Spouse:_____ ☐ Single ☐ Separated ☐ Divorced ☐ Widow

1. Do you Smoke? ☐ No ☐ Yes; If Yes: Packs/Day ____ Quit When? _____
2. Do you drink alcoholic beverages? ☐ No ☐ Yes; If yes, per week? _____
3. Do you consume caffeinated beverages? ☐ No ☐ Yes; If yes, per week? _____
4. Do you use or have you used drugs? ☐ No ☐ Yes, what kind and when? _____

Reason for today's visit?_____

Body Part: _____
When did your symptoms first appear? ☐ Yes ☐ No
Have you tried Physical Therapy? ☐ Yes ☐ No
Have you tried an anti-inflammatory? ☐ Yes ☐ No

FRANKEL Foot & Ankle

INSURANCE INFORMATION

Primary Insurance Company:_____

Insurance ID #: _____ Group No.: _____

Policyholder's Name: _____ Date of Birth: ____/___/_____
Last First Middle I.

Patient's Relationship to Insured: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone:_____ Work Phone: _____

Employer: _____

Secondary Insurance Company: _____

Insurance ID #: _____ Group No.: _____

Policyholder's Name: _____ Date of Birth: ____/___/_____
Last First Middle I.

Patient's Relationship to Insured: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone:_____ Work Phone: _____

Employer: _____

PLEASE COMPLETE THIS SECTION IF THIS IS A WORKER'S COMPENSATION INJURY OR AUTO ACCIDENT

☐ **Worker's Comp.** ☐ **Auto Accident**

Patient Name: _____
Last First Middle I

Date of Injury: _____/_____/_____ **Body Part:** _____

Auto Insurance Carrier: _____

Claim #: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____

Contact Name: _____ **Phone:** _____

FRANKEL Foot & Ankle

Frequently Asked Questions Regarding the Credit Card on File Agreement

Do I have to leave my credit card information to be a patient at this practice?
Yes. This is our policy and it is a growing trend in the healthcare industry. Insurance reimbursements are declining and there has been a large increase in patient deductibles. These factors are driving offices to either squeeze more patients into shorter periods of time or to stop accepting insurance. We have decided to focus on becoming more efficient in our billing and collections processes instead.

How much and when will money be taken from my account?
The insurance companies on average take approximately 2 weeks to process submitted claims. Whatever the allowed amount is, your copay, coinsurance, and deductible are taken into consideration. It simply depends on your individual policy what you may owe. Once the insurance explanation of benefits is received and posted to your account, you will be sent a statement showing your portion. You will have 30 days to send an alternative form of payment if you prefer. If no alternative payment is received, your patient financial responsibility will be processed.

How do you safeguard the credit information you keep on file?
We use the same methods to guard your credit card information as we do for your medical information. The card information is securely protected by the credit card processing component of our **HIPAA** compliant practice management system. This system stores the card information for future transactions using the same sort of technology that any online retailer would. We can't see the card number — only the last four numbers, giving us no way to use the card outside of the billing system. There is no way to export the card information out of our system. The only way to use it is to process a payment in our practice management system.

What are the benefits?
It saves you time and eliminates the need to write checks, buy stamps or worry about delays in the mail. It also drives our administrative costs down because our staff sends out fewer statements and spends less time taking credit card information over the phone or entering it from the billing slips sent in the mail, which are less secure methods than us storing the information. The extra time the staff has can now be spent on directly helping the patients, either over the phone, with insurance claims or in person.

I always pay my bills on time. Why do I have to do this?
The entire billing process is time consuming and wasteful, and the few patients that we do have to send to a collection agency end up costing a lot of money. Reducing unnecessary costs are essential to allowing us to continue to be an in-network provider with most insurance companies. Nothing is changing about how much you end up paying.

What if there is a payment discrepancy or I have other payment questions?
Please contact our billing department directly to settle payment discrepancies or for other payment questions. This policy in no way compromises your ability to dispute a charge or questions your insurance company's explanation of benefits.

Will I still receive a paper bill by mail?
Yes. You will receive one bill which will show what will be charged to your card in 30 days. If you prefer to pay by an alternative method, you may do so during that period. If you do not wish to make any payment method changes, just hold onto the statement for your records and your card will be charged.

CREDIT CARD ON FILE AGREEMENT

Frankel Foot & Ankle has implemented a new credit card policy. Much like many other businesses such as a hotel or car rental agency, attorneys, etc. we now have a similar policy where we ask for a credit card which may be used later to pay any balance that may be due on your bill.

Co-pays are still due at the time of service.

At check in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. At that time, you will be sent a statement which you will have 30 days to pay. After 30 days, if the bill remains unpaid, we will bill your credit card.

Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged.

If you have any questions about our policy, please do not hesitate to ask.

By signing below, I authorize Frankel Foot & Ankle to keep my signature and my credit card information securely on-file in my account. I authorize Frankel Foot & Ankle to charge my credit card for any outstanding balances when due.

If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give Frankel Foot & Ankle a new, valid credit card which I will allow them to charge over the telephone. Even though Frankel Foot & Ankle is not processing the new card in person, I agree that the card may be used with the same authorization as the original card I presented.

Visa ☐	**Master Card** ☐	**Discover** ☐	**American Express** ☐
Patient's Full Name (Print):_____			DOB:____/_____/_____
Name on Card (Print): _____			
Credit Card Number:_____			Exp. Date: _____/_____
Please fill out information below for any other person(s) you authorize this credit card for:			
Patient Full Name (Print): _____			DOB: _____/_____/_____
Patient Full Name (Print): _____			DOB: _____/_____/_____
Patient Full Name (Print): _____			DOB: _____/_____/_____

Credit Card Holder's Signature: _____ Date:_____

☐ Please check this box if you prefer not to receive a statement and would like us to bill your credit card immediately for any balances due after the processing of your insurance.

CONSENT, DISCLOSURE AND AUTHORIZATION

Patient Name: _____ DOB:_____

As used in this form, the words "I," "me," "my" and similar references means the patient whose name appears above, or the parent, legal guardian or other legally responsible person on behalf of the minor or incapacitated patient named above.

General Consent for Examination and Treatment

I hereby consent and authorize The Frankel Foot & Ankle Center ("FFAC") and all physicians and ancillary medical personnel of FFAC, to perform medical examinations and provide routine medical care for all my visits to FFAC. This may include routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. I understand that certain procedures will require a specific informed consent, and that FFAC will provide me with information and forms prior to such procedures.

This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment and healthcare operations of FFAC Any photographs or other images taken will become part of my medical record. FFAC will not use such photographs or images for any other purposes without my specific written consent.

Acknowledgment of Receipt of Notice of Privacy Practices

I have read and understand FFAC's HIPAA Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that FFAC has the right to change its HIPAA Notice of Privacy Practices from time to time and that whenever an important change is made, FFAC will post a new notice in the office. I may contact FFAC at any time to obtain a current copy of the HIPAA Notice of Privacy Practices. I may also access a copy on its website.

Consent To Use and Disclose Protected Health Information for Treatment, Payment and Health Care Operations

I hereby consent and authorize FFAC to use and disclose my health information, which includes all or any part of my medical records, including drug or alcohol treatment information, genetic, genetic counseling and genetic testing information, HIV/AIDS information, and any other information concerning my diagnosis or treatment, as well as demographic information, by and to its workforce members and to health care professionals, insurance companies, medical facilities, physicians and vendors or suppliers involved, or who may become involved, with my treatment, the payment for my treatment and/or the health care operations of FFAC. I understand that, for example, my health information may be used or disclosed by FFAC to: provide for my care and treatment; communicate among various health care professionals who are involved in my care or treatment; bill for and obtain payment for care and treatment provided by FFAC; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; and conduct its business and health care operations. In addition, I understand FFAC may release my protected health information as required by law or court order.

Patient Name: _____

Disclosures to Authorized Individuals

I understand that FFAC may release my PHI to a family member, friend, or other person I indicate is involved in my care unless I object. I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care (circle as applicable), to whom the information circled "yes" below may be released:

Name: _____Relationship: _____

Address/Phone: _____

Health Info: Yes/No [circle as applicable] Payment Info: Yes/No [circle as applicable]

Name: _____Relationship: _____

Address/Phone: _____

Health Info: Yes/No [circle as applicable] Payment Info: Yes/No [circle as applicable]

Name: _____Relationship: _____

Address/Phone: _____

Health Info: Yes/No [circle as applicable] Payment Info: Yes/No [circle as applicable]

Name: _____Relationship: _____

Address/Phone: _____

Health Info: Yes/No [circle as applicable] Payment Info: Yes/No [circle as applicable]

Contact Information

I wish to be contacted in the following manner (Please check all that apply):

□ Home Telephone □ Detailed Message □ Call Back Message Only

□ Work Telephone □ Detailed Message □ Call Back Message Only

□ Cell Telephone □ Detailed Message □ Call Back Message Only

I understand that if I have checked the box "detailed message," I agree that FFAC may leave any of the following detailed messages at the indicated telephone number: appointment reminders, insurance/financial issues, biopsy or other test results, and any other information regarding care/treatment.

Patient Name:_____

Use of Consent and Authorization

A copy of this consent and authorization may be used in place of the original.

Consent and Authorization

I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my health information and about the contents of this form. I acknowledge, consent and agree to the terms and conditions of this document:

Patient Name_____ Date _____

Patient Signature_____

Authorized Individual (Parent/Guardian) Name_____

Authorized Individual Signature _____

Basis of Authority (e.g., parent, guardian): _____

FINANCIAL POLICY

1. **Insurance.** We participate with most major insurance plans, including Medicare. Knowing what benefits your insurance plan provides for you is your responsibility. Please contact your insurance company with any questions. If we participate with your insurance carrier, all services provided in our office (unless otherwise indicated) will be submitted to your insurance.

   If we do not participate with your insurance or if you do not have health insurance, payment in full is expected from you at the time of your visit. You may also inquire about the payment plans that may be available.

2. **Proof of Insurance.** All patients must complete our patient registration forms before seeing the doctor. Photo identification and a current valid insurance card are required at every visit to provide proof of insurance. It is your responsibility to verify that the office staff has the most current and correct information regarding your health insurance policy. Failure to provide current information may result in non-coverage for services provided, and the resulting charges will be your responsibility.

3. **Co-payments and Deductibles.** In accordance with your insurance plan and services provided, you are responsible for any and all co-payments, deductibles, and coinsurances. Copays, deductibles and coinsurance are due at the time of service.

4. **Referrals.** In accordance with your insurance carrier it is your responsibility to know if a written referral is required to see a specialist, or for a certain procedure. When a referral is not presented at the time of service to the provider, the patient may be responsible for payment in full at the time of service.

5. **Claims Submission.** Submission of claims is a courtesy extended to our patients. If your insurance company does not pay your claim, the balance will be billed to you. You agree to assign your insurance benefits to The Frankel Foot & Ankle Center, Dr. Frankel and/or associates/partners.

6. **Non-covered Services.** Certain office procedures or services may not be covered, or may be considered "not medically necessary", "experimental", "cosmetic" or simply "non-covered" by your insurance carrier. You are responsible for payment of these services. In the event your care exceeds a plan limitation, the balance becomes your responsibility.

7. **Non-payment of patient balances.** Should your account become delinquent, the patient or guarantor agrees to pay all costs associated with collecting the balance due including, but not limited to, attorney, collection, and contingent fees.

8. **Non-sufficient funds (NSF)/ Returned Checks.** A fee of $35.00 will be charged for all returned checks.

9. **"No Show" and Cancellation Policy:** If an appointment is missed without a notifying phone call with 24 hours' notice ("no show"), a $25 fee will be charged (this is not covered by your insurance). If an appointment is cancelled with less than 24 hours notice, we reserve the right to charge a $25 fee (not covered by your insurance). If, however, this appointment is rescheduled for another time that day or another day that week the fee will not be incurred. If 3 cancellations occur you may be discharged from our services. **I acknowledge, understand and agree to comply with this financial policy.**

_____ _____

Patient Signature Date