PREMIER FOOT & ANKLE

Patient Name:_____ Date of Birth:_____ Sex: ____M____F

Social Security #:_____ Employed:___Y___N Occupation:_____

Address: _____
Street City State Zip

Home#: _____ Work#:_____ Cell #:_____

Email:_____ ** Circle which to use for reminder calls.

Emergency Contact: _____ Phone #:_____

Primary Physicians Name: _____

Physician Contact Number: _____ Date Last Seen: _____

How did you hear about us: (Please circle)

Physician Internet Insurance Plano Profile Allen Image Friend Family

Frisco Running Company Living Magazine Frisco Running Club Other_____

Insurance Information

Primary Insurance Name: _____

Policy Holders Name: _____ Social Security #: _____

Policy Holders Date of Birth: _____ Patients Relationship to Policy Holder: _____

Married Single Divorced Widowed

EXPLANATION OF PAYMENT POLICY & PRIVACY POLICY

I hereby authorize Premier Foot & Ankle to release medical information pertinent to the filing of insurance claims for me. I authorize my insurance carrier to pay benefits directly to Premier Foot & Ankle on any unpaid services filed on my behalf. I understand that I AM RESPONSIBLE for payment to Premier Foot & Ankle for charges for the above patient regardless of my insurance coverage. I also understand that Premier Foot & Ankle is not ultimately responsible for collecting my insurance or negotiating settlements of claims. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have had the opportunity to read and understand the Notice. I also hereby give Premier Foot & Ankle permission to diagnose and administer treatment for my foot and/or ankle condition and authorize any release of information obtained in the course of my treatment. **I allow Premier Foot & Ankle to receive and release my personal and medical information that may be pertaining to my treatment, medical history and also diagnosis.**

Patient's Signature: _____ Date: _____

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Patients Name: _____ **Shoe Size:** _____

Reason for your visit: _____ **Pain Level:** _____

Alcohol Intake: _____ **Caffeine Intake**: _____
Smoker: _____ pack(s)/day X _____ years **Previous smoker**: YES NO; How much/long: _____
Height: _____ **Weight**: _____

Constitutional: Are you currently experiencing (please circle): Nausea Vomiting Fever Chills Night Sweats

Have you had a Flu shot this season? YES NO **Have you had the pneumonia vaccine?** YES NO

Medications: List current medications & dosage:

_____ _____

_____ _____

_____ _____

Past Medical History: If you now have or have ever had any of the following conditions, please circle and be more specific in the blank space below:

Thyroid Problems	Hepatitis_____	Cancer_____	Ear Disorders _____
Multiple Sclerosis	Hearing Loss	Circulation Problems	Eye Disorders _____
Heart Disease_____	ADD/ADHD	Heart Burn/Reflux	Lymphedema
Anxiety	Bipolar Disorder	Back Problems	Alcohol/Drug Dependency
Anemia_____	Currently Pregnant	Depression	High Blood Pressure
Children/Pregnancies	Fibromyalgia	Asthma	High Cholesterol
Gout	Prostate Problems	Breathing Problems	Current Kidney Dialysis
Osteoarthritis	Lupus	Pre Diabetes	Diabetes: Type I or Type II
HIV/AIDS	Osteoporosis/bone density	Kidney Problems_____	# of years _____
Neuropathy	Parkinson's	Alzheimer's/ Dementia	Other_____

Allergies: Yes No If yes, please list: _____
_____

Family History: Please circle any medical conditions that run in your family and write which member(s) affected

Diabetes _____ Gout _____ Heart Disease_____ Circulation Problems_____ High Blood Pressure_____

High Cholesterol_____ Other_____

Surgeries: List all surgeries you have had. Begin with the most recent. Please give the year.

_____

_____

If **diabetic**, who handles your diabetes?_____ Phone #:_____

Last A1C? _____ Performed by/Date: _____

**For those patients 65 years of age or older, do you have a living will or have someone to make decisions on your behalf? YES or NO

PREMIER FOOT & ANKLE

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctors. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, you will receive a bill.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for services or referrals; 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.
- You must inform the office of all insurances changes and authorization/ referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery or at the time of your Pre-op appointment.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office.
- Patients who are 90 days past due on their balance will be sent to collections, unless a payment plan has been put into place.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- In fairness to all of our patients, we understand that emergencies occur, but repeated no shows or cancellations with less than 24 hours' notice will result in a fee of $25.00. You might be asked to pay before you are seen by the doctor.
- Patients who come to office fifteen minutes later than scheduled appointment might be asked to reschedule.

Signature of Patient/ Responsible Party:_____ Date:_____

Printed Name of Patient/ Responsible Party:_____ Date:_____

DISCLOSURE OF PHYSICIAN FINANCIAL INTEREST

This document is to disclose that Dr. Korpinen and/or his associates have a financial interest in the following:

- Texas Health Surgery Center of Craig Ranch
- SurgCenter of Plano, LLC.

The Doctors of Premier Foot & Ankle want you to know that you do have the option to use an alternative health care facility.

Please sign below acknowledging receipt of this disclosure:

_____ _____

Patients Signature Date