WELCOME TO ACADIANA FOOT CENTERS

Please **PRINT** – This information is important for our records and your health

PATIENT INFORMATION

Patient Name: _____
First Middle Last

Date of Birth: ____/____/_____ Sex ___ M ___ F Social Security # _____

Race White ____ African American _____ Latino ___ Asian ____ Other _____

Ethnicity Not Hispanic Origin ____ Hispanic ____ Other ____

Home Address _____ Apt. _____

City _____ State _____ Zip _____

Primary Phone (____) _____-_____ Secondary Phone (____) _____-_____ Work Phone (____) _____-_____

Email _____
(By providing email, you are authorizing the use of an automated appointment reminder system to remind you of upcoming appointments)

Spouse Name _____ Spouse DOB _____ Phone (____) ____-_____

Emergency Contact _____ Relationship _____ Phone (____) ____-_____

Primary Care Doctor _____ Date last seen _____

FINANCIAL INFORMATION

Is the patient responsible for all bills? _____

If no then:

** Guarantor _____ Relationship to patient _____

Home Address _____ City_____ State _____ Zip _____

Phone (____) ____-_____ Date of Birth: ____/____/_____

CURRENT FOOT PROBLEM

Please describe your foot problem _____

Which foot is affected? _____ Right _____ Left _____Both

Was this problem caused by an injury? ____ Yes ____ No If yes, was it work related? _____

MEDICAL HISTORY: (Have you ever had any of the following?)

Anemia	Y	N	Heart Disease/Failure	Y	N
Arthritis	Y	N	Heart Murmur	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N
Blood Clots	Y	N	Neurological Disorder	Y	N
Cancer / Type: _____	Y	N	Neuropathy	Y	N
Circulation Problems	Y	N	Open Sores	Y	N
Diabetes (Type I II)	Y	N	Skin Disorder	Y	N
Gout	Y	N	Stomach Ulcers	Y	N
Heart Attack	Y	N	Stroke	Y	N
			Vascular Issues	Y	N

Other _____

Do you take blood thinners? _____ If yes, name of medication _____

Do you use insulin? _____ Do you have any artificial joints? ___ knee ___ hip ___ other

Do you have a heart replacement valve? ____ yes ____ no

Do you have a pacemaker? ____ yes _____ no

SURGICAL HISTORY: _____

_____

ALLERGIES: ____ None known _____ Drug allergies _____

____ Latex ____ Iodine _____ Tape

CURRENT MEDICATIONS:

Please list all medications you are currently taking (Include prescriptions, over the counter medications and herbal supplements) ***** IF YOU HAVE A LIST, WE WILL COPY IT FOR YOU**

Name Dose How often do you take it?

_____

_____

_____

Pharmacy _____ Location _____ Phone (____) ____-_____

CONSENT:

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILTY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS. I REQUEST AND AUTHORIZE ACADIANA FOOT CENTERS TO DIAGNOSE AND ADMINISTER TREATMENT FOR MY CONDITION.

PATIENT SIGNATURE _____ DATE _____

ACADIANA FOOT CENTERS
FINANCIAL POLICY

We at Acadiana Foot Centers are committed to providing you with the best possible care. If you have Medical Insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding on our payment policy.

1. Full payment is expected on the day medical services are provided unless you have health insurance coverage with a plan that we have a written agreement with. Our financial policy offers you a number of payment options such as: cash, check, Visa, MasterCard, American Express and Discover. Credit card payments will incur a 3% processing fee. Patients with insurance must pay, when applicable: **Deductible-** an amount you must pay first out of your own pocket each year before insurance will pay for any services. **Co-payment-**an amount you must pay upon each visit to a doctor that is due at the time of service. **Co-insurance-**an amount which usually is a percentage of the fee that your insurance company will not pay. Deductibles, co-payment and co-insurance are patient responsibility. Custom orthotics require a deposit of $100.00 and $60.00 casting fee at the time of casting. The balance is to be paid upon orthotic dispense.

2. Insurance is a contract between you and your insurance company.

3. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.

4. It is your responsibility to ensure that our physician is in your insurance network.

5. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our providers.

6. Payment is due for rendered services 10 days from receipt of your billing statement. Unpaid previous balances must be paid in full prior to any additional visits, unless arrangements have been made with our financial counselor.

7. The returned check fee is $25.00.

8. Administrative Services: There is a $25.00 charge for forms completion for family medical leave and disability.

9. Workman's Compensation – We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

10. Personal Injury – If you are being treated as part of a personal injury lawsuit or claim, payment of the bill remains the patient's responsibility. Even if a personal injury claim or lawsuit is pending.

11. All sales are final with over the counter or DME items. Not all services are a covered benefit in all contracts. Some insurance companies refuse to cover certain services. We have no control over this.

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

If I am entitled to benefits under the Medicare, the Medicaid or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me), in consideration for services provided to me by Acadiana Foot Centers, I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered to me. I authorize payment of benefits directly to Acadiana Foot Centers, with such benefits to be applied to my bill. **I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts, deductibles, Durable Medical Equipment and any charges for services deemed to be non-covered, not pre-certified or not pre-authorized by my insurance plan.**

Patient Signature: _____ Date _____

Printed Patient Name: _____

Patient Spouse/Parent/Guarantor Signature _____ Date _____

Printed Spouse/Parent/Guarantor Name _____

_____ *(initial)* I acknowledge that I was provided or offered a copy of the Notice of Privacy Practices and that I have read and understand this form

I, _____ hereby give my permission for the persons stated below to discuss my financial and medical records, and discuss my treatment and diagnoses with Acadiana Foot Centers.

_____ _____ _____