Basic Information

Salutation ◯ Mr. ◯ Mrs. ◯ Ms. ◯ Miss ◯ Dr.

First Name

____

Middle Name

____

Last Name

____

Date of Birth

____

Address Line One

____

Address Line Two

____

City

____

State

____

Zip Code

____

Social Security Number

____

Home Phone

____

Cell Phone

____

Email Address

____

Marital Status ◯ Single ◯ Married ◯ Widowed ◯ Divorced **Gender** ◯ Male ◯ Female

Primary Language ◯ English ◯ Other ____

Preferred Pharmacy Name: ____

Pharmacy Phone Number: _____________________________

Race ◯ Not Specified ◯ American Indian ◯ Alaska Native ◯ Black / African American ◯ Native Hawaiian ◯ White

Ethnicity ◯ Latino or Hispanic ◯ Not Latino or Hispanic ◯ Not Specified

Employment ◯ Full Time ◯ Part Time ◯ Retired ◯ Unemployed

Employer

____

Emergency Contact Name

____

Relationship to Patient

____

Emergency Contact Phone Number

____

Claim Information

Primary Care Physician

____

Date Last Seen by Primary Care Physician

____

Referred to Our Office by Whom

____

Primary Insurance Carrier

____

Insured Full Name

____

Relationship to Patient ◯ Self ◯ Spouse ◯ Child

Insured Date of Birth

____

Insured Social Security Number

____

Please Provide a Copy of your Card to Our Staff Today

Privacy Information

Circle phone number and time of day where we can contact and/or leave you message(s)?

Home ◯ AM ◯ PM

Work ◯ AM ◯ PM

Cell ◯ AM ◯ PM

Name person(s) who can have access to your records and/or PHI or pick up items for you

____

Attest

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand that I am to notify Achilles Foot and Ankle Center, Inc. immediately of any changes to the above information and annually upon the office's request.

Print Patient's Name

____

Date of Signature

____

X ________________________________

Patient or Patient Representive Signature

If Signing as Patient Representative, What is your relationship to the patient?

____

Consent to Treatment

1. Consent to Treat: The undersigned consents to any initial or follow-up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, physical therapy, home instructions, orthotics, other durable medical equipment, photographing and/or videotaping and/or other services rendered to the patient by ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, BEST FOOT FORWARD MEDICAL CONSULTING, LLC and its providers. The undersign agrees that it is their responsibility to contact and/or schedule with ACHILLES FOOT & ANKLE CENTER, INC for any follow up visits, other services, prescriptions and items ordered for the patient. **The undersigned also understands that ACHILLES FOOT & ANKLE CENTER, INC's, COMMONWEALTH PODIATRY ASSOCIATES, INC's, BEST FOOT FORWARD MEDICAL CONSULTING, LLC's providers exercise their care with reasonable skill and diligence, but make no guarantee as to the results or cure that will be attained.**

2. Assignment of Benefits: I hereby irrevocably assign, transfer and convey to ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, BEST FOOT FORWARD MEDICAL CONSULTING, LLC and any practitioner providing care and treatment to me/my child, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I received from ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC.

3. Medicare Assignment: I certify that the information given by me in applying for payment under XVIII of the Social Security Act is correct and agree to complete the Medicare screening form annually. I authorize the release of information concerning me to the Social Security Administration or its intermediaries as well as any information needed for filing a Medicare claim; I request that payment and authorized benefits be made on my behalf. I assign benefits payable for services to ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC.

4. Authorization to Release Information: I consent and authorize ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, BEST FOOT FORWARD MEDICAL CONSULTING, LLC and its agents to release my health information for the purpose of payment, treatment, and healthcare operations to any of the following: insurance company and its affiliates, any practitioner, support staff or facility involved in my plan of care or transfer of care. In addition I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy notice. The HIPAA Notice of Privacy Practices are available online at **www.achillesfootandankle.com** Individual copies are also available in the office and posted in the lobby. I have read/had the opportunity to read my HIPAA rights, which include ACHILLES FOOT & ANKLE CENTER, INC's, COMMONWEALTH PODIATRY ASSOCIATES, INC's, BEST FOOT FORWARD MEDICAL CONSULTING, LLC's fees for records.

5. Designation of Authorized Representative: I designate and appoint ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC (and its agents) as my authorized representative and authorize it to act on my

behalf to 1) request and receive a copy of the summary plan description, 2) pursue a benefit claim, 3) appeal and adverse benefit determination, and/or 4) file a legal/equitable action to recover benefits from my employee benefit plan, insurance policy, and any third-party reimbursement or prepaid health care plan. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by me/my child at ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC, any requests for documents relating to this claim and appeal of an adverse determination of the claim.

6. Financial Agreement: I hereby promise to pay for all products received or services rendered to me/my child to the extent I am legally responsible for such payment. **According to the language of the physician's insurance contract, I understand that I am responsible for all health insurance copayments, deductibles, coinsurances, OTC-over the counter convenience items and NCS-noncovered services and any other amounts that apply at the time of service or at the pre- operative appointment.** Regardless of the assignment of benefits, should the insurance misrepresent their coverage or delay payment of a claim greater than 60 days, as the designated responsible party, I am responsible for the for all monies owed to ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC. I also understand that the insurance policy is a contract between me and the insurance company; therefore the policy holder should contact the insurance carrier first when there are questions regarding explanation of benefits.

The undersigned certifies that he/she has read and understands the foregoing statements 1-6, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms. This document shall remain in force until a written revocation by me is delivered to ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC.

Print Patient's Name

____

Date of Signature

____

X ______________________________

Patient or Patient Represenetive Signature

If Signing as Patient Representative, What is your relationship to the patient?

____

Policies and Procedures

1. **Reading the following policies and procedures annually will keep you informed about our office.**
2. **Appointments**: Physicians are available by appointment during posted hours. During a medical emergency, patients should seek care at the nearest emergency room or call 911. Other critical calls should page the on-call physician after hours.
3. **Refills and Medication**: Refills are completed via a pharmacy request or through the online patient portal available at https://www.achillesfootandankle.com. Contact your plan regarding your drug coverage.
4. **Messages**: Phone messages received before 3 PM are usually returned daily. Emails are returned daily. Please allow up to 1 business day for your message or email to be returned with a response.
5. **Benefits**: ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC will reiterate the benefits that were disclosed to us by your insurance plan. **We will then collect based on the benefit level all applicable copays, deductibles, coinsurances and balances that apply at the time of service or at the pre-operative appointment.**
6. **Payment**: ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC accepts VISA, MasterCard, Discover, American Express, Cash or Checks. All checks are immediately scanned for processing. Our office does not accept temporary checks and we will contact the bank directly to verify checks over $500. In most cases, we do not offer payment plans.
7. **Insurance Claims**: ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC files claims electronically for the patient's primary contracted plan and accepts payment via the patient's assignment. ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC only files secondary claims for Medicare patients; non-Medicare patients may request itemized statements to file to multiple carriers.
8. **Multiple Policies**: When multiple policies exist, it is the policy holder's responsibility to inform ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC of their primary plan. Delayed filing to the primary plan can result in violating timely filing limits, resulting in a denial of service and full patient financial responsibility.
9. **Insurance Networks**: ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC only files claims to carriers whom we have a contractual relationship; our in-network list is available upon request or on our website.
10. **Liability Claims**: ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC does accept workers compensation, personal injury protection, and letters of protection or other liability claims. If these claims are not paid in full by the liability carrier within 60 days of service, these types of claims are to be paid in full by the patient according to the payment policy.
11. **Non-Covered Services:** ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC will not submit claims for non-covered items.
12. **Referrals**: ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC may refer patients to other providers, facilities, and labs. ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC is not responsible for these entities.
    The patient should contact these providers, facilities or labs directly regarding any billing questions. The policy holder is also responsible for all insurance prior authorizations and/or managed care referrals necessary for payment to ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC.
13. **Missed Appointments**: A $50 charge will apply for appointments broken or canceled without 24 hours advanced notice.

14. **Appointment Hold**: Repetitive broken appointments, non-compliance, hostile behavior, and/or financially deficient accounts will result in appointment hold and/or the termination of the ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC Doctor- Patient relationship. 30 days' advance notice will be given should the situation result in a transfer of the patient's care.
15. **Patient Balance Statements**: ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC will send a remainder or balance statement to the patient when the benefits have been misrepresented by the carrier. Each statement will be accessed a $10 rebilling fee for each month that it is reissued.
16. **Delinquent Accounts**: Past due accounts are subject to collection proceedings and are reported to the credit bureau. All collection fees, attorney fees and court fees shall become the patient/guarantor's responsibility in addition to the balance due the office. A minimum fee of 33% of the past due balance will be added to the balance due to the office.
17. **Returned Checks**: A $75.00 fee will be assessed on all returned checks. Any NSF or Closed Account will result in future services on a pre-pay cash or credit basis. The Commonwealth's Attorney's Office will prosecute unresolved checks.
18. **Refunds**: ACHILLES FOOT & ANKLE CENTER, INC, COMMONWEALTH PODIATRY ASSOCIATES, INC, and/or BEST FOOT FORWARD MEDICAL CONSULTING, LLC issues patient refunds by check within 30 days of a completed investigation of the potential overpayment, as long as other outstanding accounts have been resolved.
19. **Returns**: Only unworn and non-custom items are returnable within 7 days of receipt, if no visible signs of wear, tear, or odor. Durable medical equipment including but not limited to walking boots, prefabricated braces and night splints are not returnable due to health department policies. However, the durable medical equipment can be replaced according to the policy and procedures provided at the time of dispensing of the item. Custom items are tailored to meet individual needs; custom items are non-returnable, non-refundable.
20. **Medical Records**: The cost for copied medical records and completion of disability forms will be charged to the patient and collected prior to replicating. The fees for these services are regulated by HIPAA. All medical record requests and forms must be completed through our online patient portal at https://www.achillesfootandankle.com

The undersigned certifies that he/she has read and understands the foregoing 1-20 statements, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.

Print Patient's Name

____

Date of Signature

____

X ________________________________

Patient or Patient Represenive Signature

If Signing as Patient Representative, What is your relationship to the patient?

____

MEDICAL HISTORY

Reason for Today's Visit

Patient's Name (Last, First, M.I.): | Date:

Please describe current problem:

Which lower extremity: ❑Left ❑Right | How long has this problem troubled you:

Have you undergone previous treatment for this problem: ❑Yes ❑No If yes, please describe:

Is your problem a result of injury: ❑Yes ❑No If yes, date of injury: | Did injury occur while at work: ❑Yes ❑No

Medications (prescription and nonprescription medications)

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

Allergies

Please indicate: ❑No known allergies ❑Yes, please list below (medication, food, materials etc.)

Medical History (please check all that apply)

	Yes	No		Yes	No
Arthritis/Bone-Joint Problems	❑	❑	Eye Problems	❑	❑
Anemia	❑	❑	Gout	❑	❑
Asthma/Breathing/Lung Problems	❑	❑	Gynecological Problems (Females)	❑	❑
Back Problems	❑	❑	Head and Neck Problems	❑	❑
Bleeding Problems	❑	❑	Heart Attack Date ____________	❑	❑
Blood or Blood Product Transfusion	❑	❑	Hepatitis/Jaundice/Liver Disease	❑	❑
Blood Clots	❑	❑	High Blood Pressure	❑	❑
Cancer	❑	❑	High Cholesterol	❑	❑
Chemotherapy	❑	❑	Injury/Trauma Kidney Problems	❑	❑
Chest Pain/Heart Problems	❑	❑	Kidney Dialysis (Circle Days) M T W T F S S	❑	❑
Circulatory Problems	❑	❑	Lower Extremity Wounds	❑	❑
Diabetes	❑	❑	Lyme Disease	❑	❑
Dropfoot	❑	❑	Neuromuscular Disease	❑	❑
Ear/Nose/Throat Problems	❑	❑			

Medical History (Please check all that apply)

	Yes	No		Yes	No
Numbness or Weakness	❑	❑	Seizures/Epilepsy	❑	❑
Other Serious Illnesses	❑	❑	Sickle Cell Disease or Trait	❑	❑
Pacemaker	❑	❑	Skin Problems	❑	❑
Polio	❑	❑	Stroke Date: ___________	❑	❑
Positive Culture for MRSA/VRE	❑	❑	Stomach/Intestinal Problems/Ulcers	❑	❑
Positive Test for HIV	❑	❑	Tetanus Immunization Date:___________	❑	❑
Previous Diabetic Foot Wounds	❑	❑	Thyroid Problems	❑	❑
Prostate Problems (Males)	❑	❑	Tuberculosis	❑	❑
Psychiatric/Emotional Disorder	❑	❑	Urinary Tract Problems	❑	❑
Recent Weight Gain/Loss	❑	❑	Venereal Disease	❑	❑

Family History

Father: Living________ Deceased_______ Mother: Living________ Deceased_______ Siblings: indicate # of siblings _________

Does or did anyone in your immediate family have any of the previously mentioned medical problems: ❑Yes ❑No

If yes, please describe:

Surgical History

Previous foot or ankle surgery: ❑Yes ❑No If yes, please describe: ❑Right ❑Left

Previous surgery other than foot or ankle: ❑Yes ❑No If yes, please describe:

Have you ever had any anesthetic agents: ❑Yes ❑No If yes, please indicate: ____General ____Spinal ____Epidural

____Sedation _____Local _____Regional | Please describe any complications:

Do you have any internal metal, vascular or other implants (pins, grafts, screws, plates, clips, joints, etc.): ❑Yes ❑No

If yes, please describe:

Personal History

Do you smoke: ❑Yes ❑No If yes, how much:

Do you drink alcohol: ❑Yes ❑No If yes, how often:

Are you pregnant or breast feeding (females): ❑Yes ❑No If no, are you trying to become pregnant: ❑Yes ❑No

Do you participate in physical fitness activities: ❑Yes ❑No If yes, please describe:

Are you: ❑Right handed ❑Left handed ❑Both | Weight: _______________ | Height: _______________

Do you use: ____Cane ____Walker ____Brace ____Crutches ____Wheelchair ____Prosthesis

Shoe size:________________ Shoe width:________________ What type of shoes do you wear: ___________________________

If there is additional information that you think the doctor should know, please describe below.