



DEMOGRAPHICS

PATIENT INFORMATION

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

EMERGENCY CONTACT INFORMATION

Emergency Contact Name and Phone

Relationship to Patient

CLAIM INFORMATION

Primary Care Physician

Referred to Our Office by Whom

Insured Full Name

Relationship to Patient Self Spouse Child

Insured Date of Birth

Insured Social Security Number

PHARMACY INFORMATION

Pharmacy

Pharmacy Zip Code

Phone Number

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

ATTESTATION

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 Representative Signature



CONSENT

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 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 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 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.

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.

4. Authorization to Release Information: I consent and authorize ACHILLES FOOT & ANKLE CENTER, INC 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 fees for records.

5. Designation of Authorized Representative: I designate and appoint ACHILLES FOOT & ANKLE CENTER, INC (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, 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. 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.

Print Patient's Name

Date of Signature

X

Patient or Patient Representative Signature

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

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. Contact your plan regarding your drug coverage.

4. Messages: Phone messages received before 3 PM are usually returned daily. Emails are returned daily.

5. Benefits: ACHILLES FOOT & ANKLE CENTER, INC 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 accepts VISA, MasterCard, 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 files claims electronically for the patient's primary contracted plan and accepts payment via the patient's assignment. ACHILLES FOOT & ANKLE CENTER, INC 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 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 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 does not accept workers compensation, personal injury protection, and letters of protection or other liability claims. These types of claims are to be paid in full by the patient.

11. Non-Covered Services: ACHILLES FOOT & ANKLE CENTER, INC will not submit claims for non-covered items including, but not limited to cosmetic services and over the counter convenience items (OTC eg. Biofreeze, Coban, Lyncos, Mycomist, etc...)

12. Referrals: ACHILLES FOOT & ANKLE CENTER, INC may refer patients to other providers, facilities, and labs. ACHILLES FOOT & ANKLE CENTER, INC is not responsible for these entities.

The patient should contact these non-ACHILLES FOOT & ANKLE CENTER, INC 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.

13. Missed Appointments: A \$25 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 and Ankle, Inc 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 will send a remainder or balance statement to the patient when the benefits have been misrepresented by the carrier. Each statement will be assessed 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 of 33.33% plus an annual interest rate of 18% and court fees shall become the patient/guarantor's responsibility in addition to the balance due the office.
- 17. Returned Checks:** A \$50.00 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 District Attorney's Office will prosecute unresolved checks.
- 18. Refunds:** ACHILLES FOOT & ANKLE CENTER, INC 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. 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.

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 Representative Signature

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