# Patient Demographics Form

Chart No:_____

FOOT & ANKLE INSTITUTE

**We appreciate your help in updating our records and acquiring any new information per government regulations.**

Regulation required **ALL FIELDS below** be completed

Name:_____ Preferred Name: _____Birth Date:_____

Local Address: _____
Street City State Zip code

Mailing Address: _____
**(If different than above)** City State Zip code

Preferred Phone # (_____) _____ (H) (C) Alternate Phone # (_____) _____(H) (C)
**Indicate home/cell** **indicate home/cell**

Email Address: _____ Female _____ Male _____

Social Security Number: _____-_____-_____ **HOW DID YOU HEAR ABOUT Foot & Ankle Institute?** _____

Name of Parent: **(if under age 18)** _____Phone# _____

Emergency Contact: _____-_____ Phone #_____
Name **relationship to patient**

Name of the Legal Guardian _____**(we must have a copy of the legal guardianship documents)**
Name of your Power of Attorney _____ medical _____ legal _____
**(we must have a copy of the legal documents for your Power of Attorney)**

Primary Care Physician: _____ Referring Physician: _____

Health Insurance coverage-
When **YES,** means you are authorizing us to bill on your behalf, by YOU providing the insurance card(s) for your active coverage, for our records. Please fill out the requested information below for the main member's details.

When **NO,** insurance card(s) are provided, showing active coverage, YOU WILL BE REQUIRED TO PAY at the time of service.

| **Primary** Insurance | |
|---|---|
| **What is the main member's name:** | **Relationship:** |
| **What is the main member's date of birth:** | |
| Copy of insurance card **MUST** be provided. **If a card is not provided you will have to pay for the visit.** | |

| **Secondary** Insurance | |
|---|---|
| **What is the main member's name:** | **Relationship:** |
| **What is the main member's date of birth:** | |
| Copy of insurance card **MUST** be provided. **If a card is not provided you will have to pay for the visit.** | |

**If a Workers Comp claim was filed, please provide adjustor's name: _____**
**Contact Phone#** _____ **Claim number:** _____
**Employer:** _____ **Phone#:** _____
IN ORDER TO FILE WORKERS COMP CLAIMS, AUTHORIZATION FROM THE ADJUSTOR'S OFFICE IS REQUIRED.
If not, health insurance coverage must be provided or cash payment in full is required. (a referral is not an authorization)

**Employee:** _____ **Date:** _____



**See other side or next page**

Patient's Name: _____ Chart # _____

## Medicare Patient Agreement (for Medicare patient's only)

**Medicare member's Name**_____ Medicare Subscriber Number _____

I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf to Foot & Ankle Institute and/or South Main Surgery Center for any services furnished to me by that provider. I authorize any holder of medical information and any information needed to determine these benefits or the benefits payable for related service about me to release this information to The Center for Medicare & Medicaid Services and its agents. This authorization is in effect until I choose to revoke this authorization in writing.

**MEDICARE MEMBER'S SIGNATURE**: _____ **Date:** _____

## CREDIT AND FINANCIAL CHARGE AGREEMENT

By signing below, I hereby authorize any benefits due to be paid directly to Foot & Ankle Institute and or South Main Surgery Center at 754 S. Main Street, Suite 3 St. George Utah 84770. I understand and agree that I am financially responsible for all deductible, co-insurance, co-pays, and non-covered service(s) or service(s) deemed as "non-medically necessary" by my benefit plan. I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred**. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein.** I agree that a late fee on all past-due balances until paid in full. In the event any amount(s) is/are referred to a third-party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principal amount(s) owing as allowed by state law, whether it be for the state of *Utah, Nevada, or Arizona*, based on location. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today. **PROOF OF INSURANCE**: ***All patients must complete our patient information form before seeing the doctor. You must provide valid and accurate insurance information in a timely manner, or you may be responsible for the balance of any claim(s) we file on your behalf***. If payment is made it will be held and will become nonrefundable if the proper information is not provided within a reasonable time frame based on the member's insurance benefit carrier. **If no insurance information is provided at time of service or no active benefits through medical coverage are available. I agree to pay the self-pay rate at the time service(s) is provided.**

I also hereby expressly consent to receiving voice and or SMS (text) messages (including pre-recorded messages) on my mobile or any other telephone number(s) that I provide (either directly or through an intermediary) to Foot & Ankle Institute, Inc. I under and agree that such messages may be sent by Foot & Ankle Institute, may be sent via automated dialing technology (autodialed) and may consist of such things as appointment reminders and/or collection efforts.

**BY SIGNING BELOW, I AGREE TO THE ABOVE STATEMENT AND ACKNOWLEDGE RESPONSIBILITY**

## Medical Information Release

I acknowledge that I have been provided a copy of the NOTICE OF PRIVACY PRACTICES of Foot & Ankle Institute and that Foot & Ankle may release all or portions of my medical record to me, and to people or companies responsible to pay the charges for my care, such as my insurance or health benefits companies, or workers compensation carriers. I further acknowledge that Foot & Ankle Institute may disclose my patient information to referring or treating health care providers and for payment and health care operations. I hereby authorize Foot & Ankle Institute to obtain my medical information from other health care entities and providers, including but not limited to, copies of lab results, diagnosis test reports, films/images and other clinical information deemed necessary by Foot & Ankle Institute's physician's or representatives. I understand that I may inspect my protected heath information, request more information, and revoke this authorization, as permitted by the federal privacy regulations and in accordance with Foot & Ankle Institute's privacy policy.

**BY SIGNING BELOW, I AGREE WITH THE ABOVE STATEMENT AND ACKNOWLEDGE PRIVACY PRACTICES**

## Consent to Treat

I hereby consent to the medical treatment, diagnostic tests and other procedures, which Keith R. Reber, DPM and/or S. Kent Burton DPM and/or Lary J. Smith, DPM and/or Carl C. Van Gils, DPM and/or Andrew B. Powell, DPM and/or Leon K. Reber, DPM and/or Brad S. Webb, DPM and/or Victor K. Myers, DPM and/or Carla Weaver, APRN and/or South Main Surgery Center may deem advisable in treatment of my podiatric care.

**BY SIGNING BELOW, I ACKNOWLEDGE THE ABOVE STATEMENT CONSENTING TO BE TREATED BY FOOT & ANKLE PHYSICIANS**

Patient signature_____ Date: _____

Parent's / Guardian: _____ Date: _____

Patient's Name: _____ Chart# _____

**PATIENT HISTORY**

What is your foot problem? _____ Duration of problem: _____

If this is due to an injury, give date of injury, description and location of injury: _____

_____

**ALLERGIES:** **Are you allergic to any of the following:**

| | | | |
|---|---|---|---|
| **Adhesive ☐Yes ☐No** | **Morphine ☐Yes ☐No** | **Latex ☐Yes ☐No** | **Iodine ☐Yes ☐No** |
| **Aspirin ☐Yes ☐No** | **Sulfa Drugs ☐Yes ☐No** | **Codeine ☐Yes ☐No** | **Penicillin ☐Yes ☐No** |

Other, please list (can use back of page) _____

**Height:** _____Ft_____In

**Weight:** _____Ibs/Kg

**SOCIAL HISTORY:**

Do you Smoke? ☐Never ☐ Former ☐ Everyday

Do you Chew Tobacco? ☐ Never ☐ Former ☐ Everyday

**IMMUNIZATIONS:**

If over age 65, have you had a pneumonia vaccine? ☐ Yes ☐ No If yes, Date:_____

**REVIEW OF SYSTEMS/MEDICAL HISTORY**:

Please circle/check the conditions for which you have been or are currently being treated for:

| | | | | |
|---|---|---|---|---|
| **Cardiovascular:**<br>□ Rheumatic Fever<br>□ Heart Attack<br>□ Congestive Heart Failure<br>□ Hypotension<br>□ Hypertension<br>□ Murmur □ Angina | **Endocrine:**<br>□ Diabetes □ **Type 1** □ **Type 2**<br>□ Managed by: □ **Diet** □ **Insulin**<br>□ **Oral Medication**<br>□ Last A1c Value: _____<br>□ Hypoglycemia<br>□ Thyroid Dysfunctions | **Skin:**<br>□ History of MRSA<br>□ Lesions<br>□ Moles<br>□ Eczema<br>□ Rashes | **Gastrointestinal:**<br>□ Hepatitis<br>□ Liver Dysfunction<br>□ Ulcers<br>□ Hiatal Hernia<br>□ Reflux<br>□ Diverticulitis | **Respiratory:**<br>□ Asthma<br>□ Pneumonia<br>□ Short of Breath<br>□ Emphysema |
| **Musculo-Skeletal:**<br>□ Joint Pains<br>□ History of Osteoarthritis<br>□ Rheumatoid Arthritis | **Musculo-Skeletal:**<br>□ Serious injuries or disorders of the Back<br>□ Deformities<br>□ Loss of Strength<br>□ Fibromyalgia | **Hematologic:**<br>□ Anemia<br>□ Bleeding Tendencies | **Genitourinary:**<br>□ Bladder Problems<br>□ Prostate Problems<br>□ ESRD, CRF, ARF<br>□ Renal Insufficiency<br>□ Receiving Dialysis | **Neurologic:**<br>□ Weakness<br>□ Numbness<br>□ Strokes<br>□ Seizures<br>□ Migraines |

Do you have any other condition or disease we should know about? _____

_____

_____

**CURRENT MEDICATIONS:**

**(Please complete as much of the following information as possible, use back of page if needed, OR *attach a list*)**

| Name | Name | Name |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Diabetic Physician's Name**: _____ Phone# _____

**Preferred Pharmacy:** _____ **Phone:** _____

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**Patient/Guardian Signature:** _____ **Date:** _____

Revised 08/2020

Employee Signature:_____ Date: _____

FOOT & ANKLE INSTITUTE

# PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of Foot & Ankle Institute/South Main Surgery Center not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to received information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you, anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check the line to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: _____yes ___no ___ Ph#_____

Parent: _____ yes ___no ___ Ph#_____

Other: _____yes __ no ___ Ph# _____

_____yes __ no ___ Ph# _____

_____yes __ no ___ Ph# _____

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you wish to be contacted by us in a certain way.

I hereby request the following means of contact only:

_____

_____

**PRINTED NAME** _____

**Patient/Parent/Legal Guardian Signature:** _____

Date: _____ (authorization good for 1 year from date of signed authorization)

***** Patient is responsible for any changes and or updates to this form. Notify office immediately for changes to take place to your "authorized to discuss account" record. *****

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FOR OFFICE USE - Changes to above authorized by patient over phone

Change Date Staff Initials _____ date: _____