FOOT & ANKLE MANAGEMENT GROUP

Podiatry - Foot Surgery - Disease of the Foot and Ankle

We are pleased to welcome you to our practice. Please take a few moments to fill out this form as complete as possible. We look forward to working with you in maintaining your health!

Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Middle Initial This information will stay private

Birth Date _____ Age _____ Address _____

City _____ State _____ Zip _____ Mobile phone _____

Email _____ Home phone _____

Sex: ☐ Male ☐ Female Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Employed ☐ Unemployed ☐ Self Employed ☐ Student ☐ Retired ☐ Disabled

Emergency Contact _____ Relation _____ Phone Number _____

Pharmacy _____ Address & Phone _____

Who may we thank for referring you? _____

Insurance

Subscriber's name _____ Relation _____

Birth Date _____ Address (If different from patient) _____

City_____ State _____ Zip _____ Phone Number _____

Insurance Company _____ Policy # _____

Group # _____ P.O. Box for Medical Claim Submission _____

Name of other dependents under plan _____

Additional Insurance

Is Patient Covered by a secondary insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation _____ Birth Date _____

Insurance Company _____ Policy # _____

Group # _____ P.O. Box for Medical Claim Submission _____

Name of other dependents under plan _____

PLEASE COMPLETE BOTH SIDES

Patient Podiatric and Health Information

Family Physician _____ Last Office Visit _____

What is the nature of your foot problem? _____

_____

Height _____ Weight _____ Shoe Size _____

Are you in good general health ☐ Yes ☐ No If no, please explain _____

_____

Are your feet sore at the end of the day? ☐ Y ☐ N

Do you have lower back pain? ☐ Y ☐ N

Have you broken a bone in your foot/ankle ☐ Y ☐ N

Have you had foot/ankle surgery? ☐ Y ☐ N

Do you use tobacco products? ☐ Y ☐ N

If yes, what amount daily? _____

Medical History

Check (✓) if you have had any of the following:

☐ Arthritis, Rheumatism	☐ Cramps/Numbness in feet	☐ Diabetes	☐ Kidney Trouble
☐ Asthma	☐ Swelling of feet or ankles	☐ Heart Trouble	☐ Liver Trouble
☐ Bleeding Disorder	☐ High blood pressure	☐ Varicose Veins	☐ Eye Trouble

List all allergies/sensitivities you have: _____

_____

List medications you are currently taking: _____

_____

_____

Authorization

I have reviewed the information on this questionnaire and confirm that it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical information/status, I will inform the doctor.

I authorize Foot and Ankle Management Group to obtain my medical history and medications via paper or electronically.

I authorize my insurance company to pay to the doctor or medical group and all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Foot and Ankle Management Group to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

*** Payment is due in full at the time of treatment unless prior arrangements have been made ***

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JOHN R. SALM D.P.M. THERESE M. HIXON D.P.M. CLIFF W. BURMEISTER D.P.M. KATIE BACKSTRAND D.P.M. BEN MCMANUS D.P.M

CANCELLATION / NO SHOW POLICY

At Foot and Ankle Management Group, we strive to provide high-quality care to all our patients. In order to maintain efficient scheduling and ensure availability for all patients, we have implemented the following Cancellation & No-Show Policy:

We kindly request at least 24 hours notice for any appointment cancellations or rescheduling. This allows us to offer the appointment slot to another patient in need of care. **Cancellations made less than 24 hours in advance may be subject to a cancellation fee of $50 (fifty dollars).**

A "no-show" is when a patient misses an appointment without providing prior notice.

- First-time no-shows may receive a courtesy reminder.
- Repeated no-shows may incur a fee of $50
- Excessive no-shows may result in dismissal from the practice.

If you arrive more than 15 minutes late, we may need to reschedule your appointment to avoid delays for other patients. Late arrivals maybe treated as a missed appointment and subject to the no-show fee.

FEE NOTIFICATION AND PAYMENT TERMS

Please be advised that this fee will be billed directly to you and is not covered by your insurance provider. The outstanding balance is due in full prior to your next scheduled appointment. If no appointment is scheduled, payment is expected promptly. Failure to remit payment in a timely manner may result in the balance being referred to collections.

We understand that emergencies and unforeseen events happen. Fees may be waived at the discretion of the provider or office manager on a case-by-case basis.

I hereby acknowledge that I have read and understand the cancellation and no-show policy of Foot and Ankle Management Group. I accept responsibility for managing my appointments in a timely manner and agree to notify the practice promptly should I be unable to fulfill any scheduled appointment.

PRINT NAME_____

SIGNATURE_____

DATE SIGNED _____

681 GOODLETTE ROAD #160 NAPLES, FL 34102
1865 VETERANS PARK DRIVE #202 NAPLES, FL 34109
815 BALD EAGLE DRIVE MARCO ISLAND, FL 34145
(239)263-0200 WWW.FOOTANDANKLEMGMT.COM

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FINANCIAL POLICY

I acknowledge and understand that I am ultimately responsible for payment of all services rendered by Foot and Ankle Management Group, regardless of insurance coverage or treatment outcomes. I understand that additional charges may be applied to my account for returned checks and for the re-billing of statements on delinquent accounts. Accounts that remain unpaid may be referred to a collection agency, and I understand that I will be responsible for any associated collection costs. I may also be responsible for attorney fees and court costs incurred in the collection of unpaid balances.

ALL APPLICABLE COPAYMENTS, COINSURANCE, AND DEDUCTIBLE AMOUNTS ARE DUE AT THE TIME OF SERVICES ARE RENDERED.

INSURANCE AUTHORIZATION AND MEDICAL RECORD RELEASE

I authorize Foot and Ankle Management Group to release any medical information necessary to process claims with my insurance company(s) and to my referring physician(s) as needed for continuity of care. I authorize my insurance company to make direct payment of medical benefits to Foot and Ankle Management Group or the designated party accepting assignment. This authorization applies to all services and treatments provided during each office visit.

NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT

I acknowledge that I have been provided access to, and upon request may receive a copy of, Foot and Ankle Management Group's Notice of Privacy Practices. I have had the opportunity to review the notice and understand its contents.

PRINT NAME _____

SIGNATURE _____

DATE SIGNED _____

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