Patient Registration Full

Basic Contact Information

Last Name	**First Name**
Middle Name or Initial	
Address	
City	**State**
Zip Code	**Primary Phone**
Cell Phone:	**Work Phone**
E-mail Address	
Which number(s) for reminder calls? ❑ Home ❑ Cell ❑ Work	
Name Persons to have access to your records/PHI or pick up items for you:	

Patient Information

Date of Birth:	**Social Security Number**
Gender: ❑ Male ❑ Female	
Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated	
Primary Language	
Race: ❑ Not Specified ❑ Asian ❑ Black/African American ❑ White	❑ American Indian ❑ Alaska Native ❑ Native Hawaiian
Ethnicity: ❑ Not Specified ❑ Hispanic/Latino ❑ Not Hispanic/Latino	

Patient Information

Primary Care Physician	**Office Phone**
Referred by: ❑ Friend ❑ Internet ❑ Newspaper ❑ Doctor	❑ Insurance ❑ Magazine ❑ Phone Book
If Doctor Referral, Physician's Name:	**Referring Physician Office Address**
Referring Physician Phone	
Your Claim is: ❑ Not Related to Work/Auto/Liability ❑ Compensable/Work Related ❑ Automobile ❑ Other Liability	
Employment ❑ Full-Time ❑ Retired	❑ Part-Time ❑ Unemployed

Patient Information

Employer Name	**Emergency Contact Name**
Emergency Contact Relationship ❑ Family ❑ Friend ❑ Spouse	
Emergency Contact Home Phone	**Emergency Contact Cell Phone**

Primary Medical Insurance Information

Primary Medical Insurance Company - Copy of card required at office.	**Insurance Eligibility Phone Number**
Medical Claims Address	
Insured Name	
Relationship to Insured ❑ Self ❑ Spouse ❑ Child	
Insured Date of Birth	**Insured Social Security #**
Member ID or Policy Number	**Group Number**
Insured Employer Name	
Insured Employer/HR Phone #	

Secondary Medical Insurance Information

Secondary Insurance Company - Only when Medicare is 1st.	
Secondary Eligibility Phone #	
Secondary Medical Claims Address	
Secondary Insured Name	
Relationship to Insured: ❑ Self ❑ Spouse ❑ Child	
Insured Date of Birth	**Insured Social Security #**
Member ID or Policy Number	**Group Number**
Insured Employer Name	
Insured Employer/HR Phone #	
I do hereby attest that this information is true, accurate, and complete t 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 Sierra Foot & Ankle immediately of any changes to the above information and annually upon the office's request.	
I agree with the above terms. ❑	

Current Medical History

Weight	**Height**
Shoe Size	
Primary Care Physician	
Referring Physician	
Date Last Seen	
Reason for Today's Visit with Us	
Earliest Date that you noticed the condition you are seeing us for:	

Current Medical History

Location (check all that apply)

- ❑ Bottom of
- ❑ In Between
- ❑ Inside of Foot
- ❑ Top of
- ❑ Left
- ❑ Right
- ❑ Other

If Other, please describe

Site

- ❑ Ankle
- ❑ Arch
- ❑ Ball of Foot
- ❑ Calf
- ❑ Foot
- ❑ Heel
- ❑ Leg
- ❑ Toe(s)
- ❑ Other

If Other, please describe | **Date Started:**

How Often?

- ❑ At Night
- ❑ Constant
- ❑ In AM
- ❑ Off and On
- ❑ Rarely
- ❑ Recurrent
- ❑ Other

If Other, please describe

Feels Like (Please check all that apply:)

- ❑ Aching
- ❑ Bruised
- ❑ Burning
- ❑ Cramping
- ❑ Deep
- ❑ Dull
- ❑ Improving
- ❑ Inflamed
- ❑ Itchy
- ❑ Numb
- ❑ Pressure
- ❑ Sharp
- ❑ Swollen
- ❑ Tender
- ❑ Tight
- ❑ Tingling
- ❑ Other

If Other, please describe

Pain Scale (0 = No Pain, 10 = worst pain)

- ❑ 1
- ❑ 2
- ❑ 3
- ❑ 4
- ❑ 5
- ❑ 6
- ❑ 7
- ❑ 8
- ❑ 9
- ❑ 10

Pain Scale

- ❑ Improving
- ❑ Resolved
- ❑ Unbearable
- ❑ Unchanged

Caused By

- ❑ Barefoot
- ❑ Fell
- ❑ Increased Activity
- ❑ Injury
- ❑ Running
- ❑ Unknown
- ❑ Other

If other, please explain:

Better With

- ❑ Compression
- ❑ Elevation
- ❑ Heat
- ❑ Ice
- ❑ In Shoes
- ❑ Medication
- ❑ Rest
- ❑ Other

If Other, please describe

Worse With

- ❑ Increased Activity
- ❑ In Shoes
- ❑ No Shoes
- ❑ Pressure
- ❑ Running
- ❑ Walking
- ❑ Other

If Other, please describe

Also Have (Please check all that apply):

- ❑ Back Pain
- ❑ Dementia
- ❑ Diabetes
- ❑ Fatigue
- ❑ Headaches
- ❑ Infection
- ❑ Muscle Spasm
- ❑ Numbness
- ❑ Osteoporosis
- ❑ Over Weight
- ❑ Swelling
- ❑ Wear Orthodics
- ❑ Weakness
- ❑ Other

If Other, please describe

Current Problem

Symptoms:
- ❑ None
- ❑ Chills
- ❑ Excessive Weight Gain/Loss
- ❑ Fatigue
- ❑ Fever
- ❑ Loss of Appetite
- ❑ Night Sweats

Eyes:
- ❑ NONE
- ❑ Double Vision
- ❑ Dry Eyes
- ❑ Loss of Vision
- ❑ Pain
- ❑ Redness
- ❑ Other

If Other, please describe

Ears, Nose, and Throat:
- ❑ NONE
- ❑ Ear Pain
- ❑ Ear Ringing
- ❑ Dizziness
- ❑ Hearing Loss
- ❑ Hoarseness
- ❑ Loss of Smell

Heart:
- ❑ NONE
- ❑ Chest Pain
- ❑ Rapid Heart Rate
- ❑ Shortness of Breath
- ❑ Swelling in Legs or Feet

Respiratory:
- ❑ Productive Cough
- ❑ Shortness of Breath
- ❑ Snoring
- ❑ Sleep Apnea
- ❑ Wheezing
- ❑ Other

If Other, please describe

Intestinal:
- ❑ NONE
- ❑ Abdominal Pain
- ❑ Bloating/Gas
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea
- ❑ Vomiting

Urinary, Reproductive:
- ❑ NONE
- ❑ Blood in Urine
- ❑ Pregnant
- ❑ Urinary Incontinence
- ❑ Sexually Transmitted Disease

Musculoskeletal
- ❑ NONE
- ❑ Artificial Joints
- ❑ Soft Tissue Pain
- ❑ Weakness
- ❑ Other

If Other, please describe

Skin:
- ❑ NONE
- ❑ Ingrown Nail
- ❑ Lesion
- ❑ Non-healing Wound
- ❑ Rash
- ❑ Ulcer
- ❑ Wart
- ❑ Other

If Other, please describe

Neurological:
- ❑ NONE
- ❑ Memory Loss
- ❑ Migraines
- ❑ Numbness
- ❑ Paralysis
- ❑ Seizures
- ❑ Strokes

Psychiatric
- ❑ NONE
- ❑ Anxiety
- ❑ Claustrophobia
- ❑ Depression
- ❑ Hallucinations
- ❑ Restlessness

Endocrine:
- ❑ NONE
- ❑ Cold Intolerance
- ❑ Diabetes
- ❑ Excessive Thirst
- ❑ Excessive Urination
- ❑ Heat Intolerance

Hematological
- ❑ NONE
- ❑ Anemia
- ❑ Blood Transfusions
- ❑ Easy Bruising
- ❑ Prolonged Bleeding
- ❑ Other

If Other, please describe

Current Problem

Immunologic

- ❑ NONE
- ❑ HIV
- ❑ Allergies
- ❑ Recurrent Infections
- ❑ Other

If Other, please describe

Pharmacy and Current Medications

Pharmacy:

Location:

Zip Code: | **Phone #:**

I take NO Medications ❑

Relationship to Patient

Patient Name or Legal Authorized Representative

Date:

By clicking Submit you are providing this medical information to Sierra Foot & Ankle.

Allergies, Procedures & Conditions

Allergies (Mark NONE if the allergies below do NOT apply to you):

- ❑ NONE
- ❑ Adhesive/Tape
- ❑ Anesthetics, Local
- ❑ Aspirin
- ❑ Blood Thinners
- ❑ Codeine
- ❑ Dairy
- ❑ Eggs
- ❑ Demerol
- ❑ IV
- ❑ Other

If Other, please list here:

Previous Foot Procedures (Check NONE if the procedures do NOT apply to you):

NONE	❑
Amputation	❑
Bunion	❑
Hammer Toe	❑
Ingrown Nail	❑

Previous Surgeries:

- ❑ Angioplasty/Stent
- ❑ Appendectomy
- ❑ Back/Spine Surgery
- ❑ Blood Transfusion
- ❑ Cesarean Section
- ❑ Defibrillator
- ❑ Gallbladder Surgery
- ❑ Gastric Bypass Surgery
- ❑ Heart Bypass Surgery
- ❑ Heart Valve Replacement
- ❑ Hysterectomy
- ❑ Joint Replacement
- ❑ Lap Band
- ❑ Lower Extremity Bypass
- ❑ Pacemaker
- ❑ Tonsilectomy
- ❑ Transplant
- ❑ Other

If Other, please describe

Past Medical History (Mark NONE if the history below does NOT apply to you):

- ❑ NONE
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Blood Clots
- ❑ Callus Formation
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Circulation Problems
- ❑ Depression
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Foot Ulceration(s)
- ❑ Gout
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ Hepatitis-List Type below
- ❑ High Blood Pressure
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Lung Disease
- ❑ Lupus
- ❑ Neuropathy
- ❑ MRSA Infection
- ❑ Osteoporosis
- ❑ Pain in Legs/Feet/Toes
- ❑ RSD/CRPS
- ❑ Seizure Disorders
- ❑ Sports-Related Injury
- ❑ Stomach Ulcers
- ❑ Stroke
- ❑ Swelling in Legs/Feet
- ❑ Thyroid Disorders
- ❑ Other

If you checked Other or Hepatitis, please describe here

Family History

Family History

	Mother	Father	Sister	Brother	Grandparents
Alive & Well	❑	❑	❑	❑	❑
Deceased	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑
Diabetic	❑	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑	❑
Unknown/None	❑	❑	❑	❑	❑

Live with:

- ❑ Aunt
- ❑ Children
- ❑ Friends
- ❑ Grandparents
- ❑ No One
- ❑ Parents
- ❑ Pets
- ❑ Partner
- ❑ Room-mate
- ❑ Sibling(s)
- ❑ Spouse
- ❑ Uncle

Live in a:

- ❑ Single Story Home
- ❑ Multi-level Home
- ❑ Hospice
- ❑ Skill Nursing Facility

Occupation:

Activities & Hobbies

- ❑ NONE
- ❑ Aerobics
- ❑ Bowling
- ❑ Cycling
- ❑ Dancing
- ❑ Hiking
- ❑ Golf
- ❑ Gymnastics
- ❑ Running
- ❑ Soccer
- ❑ Swimming
- ❑ Tennis
- ❑ Walking

Caffeine History

- ❑ NONE
- ❑ Fewer than 7 cups per week
- ❑ More than 7 cups per week

Alcohol History

- ❑ NONE
- ❑ Fewer than 7 Drinks per week
- ❑ More than 7 Drinks per week

Smoking History

- ❑ Never a Smoker
- ❑ Former Smoker
- ❑ Unknown, if ever
- ❑ Current everyday smoker
- ❑ Current social smoker
- ❑ Current status unknown
- ❑ Less than 1 park a day
- ❑ 1 pack a day
- ❑ 2 packs a day
- ❑ More than 2 packs a day

Recreational Drug History:

- ❑ Never Used Recreational Drugs
- ❑ Have Used Recreational Drugs

Authorization

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 Sierra Foot & Ankle (SFA) and its providers. The undersign agrees that it is their responsibility to contact and/or schedule with SFA for any follow up visits,other services, prescriptions and items ordered for the patient. The undersigned also understands that SFA'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 SFA 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 SFA.

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 SFA.

4. Authorization to Release Information: I consent and authorize SFA 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.sierrafootankle.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 SFA's fees for records.

5. Designation of Authorized Representative: I designate and appoint SFA (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 an 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 SFA, 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, in office dispense 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 SFA. 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 SFA.

Date:	**Patient Signature:**

Authorization and Consent for Medical and/or Surgical Treatment of a Minor

If you are NOT submitting paperwork for a minor, skip this page.

I,

Authorization and Consent for Medical and/or Surgical Treatment of a Minor

parent/legal guardian of the minor listed below do hereby give my authorization and consent for him/her to receive medical and/or surgical care to include, but not limited to, evaluations, procedures, x-rays, supplies, durable medical equipment, and/or other treatment recommended by any of the Doctors of Sierra Foot & Ankle.

I understand that I must be present at the initial appointment to discuss at length the treatment plan for the minor listed below. I understand that another adult may be authorized to bring the minor to follow up appointments. I also agree that the private health information of the said minor will be discussed with any and all of the names listed on this authorization, including the legal guardians, unless revoked in writing by the said minor or the legal authorized official.

I also understand the physician may use his professional discretion to reschedule the minor's treatment and/or procedures, should the physician feel that the parent's involvement facilitate a more positive outcome. In addition to this authorization, I have read and signed the "Authorization from Patient Legal Representative," and the "Office Policies and Procedures," so that I am fully aware of my responsibilities and the office policies. I am also aware that the office updates demographics, office policies and medical histories annually; however, this authorization does not expire, unless the said minor is of legal age, emancipation or revoked by the legal guardian in writing.

I am, by this document, representing that I have the authority to consent for all medical/surgical care and/or treatment of the minor listed below.

Patient's First Name:	**Patient's Last Name:**
Patient's Date of Birth:	**Guardian's First Name:**
Guardian's Last Name:	**Guardian's Phone Number:**
Today's Date:	**Guardian's Signature**
Name and Date Of Birth of person(s) authorized to bring Minor and their relationship to the Minor:	

Policies and Procedures

1. Patient treatment: It is our primary goal to restore and maintain the health of your feet. We strive to provide with the highest quality podiatric care. If you have any questions regarding your treatment, please feel free to consult with your physician who is providing your care. It is our responsibility to deliver the best health care possible. We highly value your confidence in our practice and we will make a sincere effort to satisfy all your podiatric needs. Your initials and signature of 1 through 20 will act as an authorization and consent for treatment.

2. It is your responsibility to understand the following policies and procedures. Reading this document annually will keep you informed about our office practices.

3. 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. Missed Appointments:We make appointment confirmation calls through an automated system as a courtesy; it is your responsibility to keep track of your appointments. A missed appointment or a late cancellation (without 24 hours advanced notice) will result in a forty dollar ($40.00)service fee. A missed office procedure will result in a seventy-five dollar ($75.00) service fee. These fees are not covered by your insurance.

4. Refills and Medication: Refills are completed via a pharmacy request. Contact your pharmacist for refill requests. For medication coverage contact your insurance plan regarding your drug coverage.

5. Messages: Phone messages received before 3 PM are usually returned that day.

6. Benefits: SFA 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.

7. Payment: Payment for your visit is due in full at the time of service. SFA accepts VISA, MasterCard, Discover, AMX, Cash or Checks, and Care Credit. 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. SFA does not offer payment plans. For those patients needing financial assistance, we offer Care Credit.

8. Insurance Claims: SFA files claims electronically for the patient's primary contracted plan and accepts payment via the patient's assignment. SFA does NOT file secondary insurance claims. However, Medicare secondary cross-over plans are submitted automatically by Medicare to the patient's secondary insurance carrier if the patient has authorized for this forwarding of information during secondary insurance enrollment. Non-Medicare patients may request itemized statements to file to multiple carriers. To ensure correct claims submission, we require a current copy of your insurance card at each visit or we consider your visit to be self-pay. We bill your primary insurance only. You are responsible for submitting claims to any secondary insurance for reimbursement. Any inaccurate information provided by the patient that causes your insurance billing to be rejected will incur a twenty-five dollar ($25.00) service fee if the patient requests a resubmission to the primary insurance carrier. This fee is not covered by your insurance.

9. Multiple Policies: When multiple policies exist, it is the policy holder's responsibility to inform SFA 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.

Policies and Procedures

10. Insurance Networks: SFA only files claims to carriers out of our in-network list as a courtesy to patients. However, these patients we treat as cash pay and fees are due at the time of service.

11. Liability Claims: SFA will accept workers compensation for in-network plans, however, we do not accept personal injury protection, and letters of protection or other liability claims. These types of claims are to be paid in full by the patient.

12. Non-Covered Services: SFA will not submit claims for non-covered items including, but not limited to cosmetic services and in-office-dispensing convenience items (OTC, eg. Biofreeze, Coban, Sole, Mycomist, etc...). Often, these items and services can be purchased with your medical savings account.

13. Referrals: SFA may refer patients to other providers, facilities, and labs. SFA is not responsible for these entities. The patient should contact these non-SFA providers, facilities or labs directly regarding any billing questions. For those patients referred to SFA by other providers, it is the policy holder's responsibility to obtain insurance authorizations and/or managed care referrals that are necessary for payment to SFA.

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 SFA 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: We file your insurance claim as a courtesy to you. You are responsible for co-pays, deductibles and any charges not covered by your insurance. SFA will send a monthly balance statement to the patient for any monies due. Upon receiving your patient statement, the patient responsibility balance is due in full at that time. Re-billing for non-payment of the patient responsibility balance will be assessed a ten dollar ($10.00) billing fee for the patient responsibility balance carried each month. Should your insurance company payment take longer than sixty (60) days, you are responsible for total charges.

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.

17. Returned Checks: A $40.00 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: SFA 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 14 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. Appropriate returns are will be issued immediately if paid by credit card only if that credit card is in possession at time of return. Otherwise, a check will be mailed within 7 business days.

20. Medical Records: The cost for copied medical records and completion of disability forms will be charged to the patient. We require a $20.00 retainer prior to replicating; the balance for this service will be due prior to release of records. The fees for these services are regulated by HIPAA and Nevada Health and Safety Code. Release of Records: If you request your records released to another physician or facility you must sign a Release of Information form indicating who we are releasing records to, as well as, which relevant information you would like us to release. If you request to receive a copy of your records for your personal files, we must receive a written request. Allow 7-10 business days to have your records to be available. SFA charges $20.00 for the first 20 pages and $0.10 for each additional page. There is a $30.00 per hour handling fee in order to copy your protected health information, and a postage fee if you want the copies mailed. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Fees also apply for all FMLA and other disability forms that we are requested to complete. Contact us using the information listed at the end of this notice for full explanation of our fee structure. HIPAA states that the covered entity must act on a request for access no later than 30 days after receipt of the request. Digital records and/or x-rays are available for a fee. Hard-copy X-rays taken within our office are our personal property which we are legally responsible to maintain with your records. Therefore we DO NOT release these original films, but can make replicates for a fee. Copies of digital X-rays are available upon request for a fee of $8.00 per CD.

I would like to access (VIEW only, NO edits) my medical record at Sierra Foot & Ankle through a secured website connection.

❑ Yes ❑ No

I agree with the above terms (1-20). ❑

Date:	**Patient Signature:**