Phoenix Foot & Ankle Associates, PC

Date: _____

Name: _____ Date of Birth: _____

Home Ph: (_____) _____ Cell Ph: (_____) _____

Work Ph: (_____) _____ Email: _____

Address: _____

SS #: _____ Age: _____ Sex: [ ] Female [ ] Male

[ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Other

Occupation: _____ Employer: _____

Work Address: _____

Primary Insurance: _____

Name of Insured: _____ Date of Birth: _____

Insured's Employer: _____ Relationship to Patient: _____

Secondary Insurance: _____

Name of Insured: _____ Date of Birth: _____

Insured's Employer: _____ Relationship to Patient: _____

Whom may we thank for referring you? _____

In case of an Emergency, contact: _____

Phone: (_____) _____ Relationship: _____

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Phoenix Foot & Ankle Associates, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am finically responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize this use of signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date

MEDICARE AUTHORIZATION, If Applicable Please Sign

I request that payment of authorize Medicare benefits be made either to me or on my behalf to Phoenix Foot & Ankle Associates, PC, for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in the item 9 of the HFCA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered service. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

1701 East Thomas Road, Suite 201, Phoenix, AZ 85016

Office: 602-251-3113 ● **phxfoot.com** ● Fax: 602-251-3114

Phoenix Foot & Ankle Associates, PC

Date: _____ Name: _____

Reason for today's visit: _____

Height: _____ Weight: _____ Shoe Size_____

Please indicate if you have or had any of the following:

[ ] AIDS/HIV
[ ] Alcohol Abuse
[ ] Allergies to Medicines/Drugs
[ ] Anticoagulant Therapy
[ ] Arthritis
[ ] Artificial Heart Valves or Joints
[ ] Asthma or Respiratory Disease
[ ] Back Problems
[ ] Bleeding Disorders
[ ] Cancer
[ ] Chemical Dependency
[ ] Chest Pain or Angina
[ ] Circulatory Problems
[ ] Diabetes
[ ] Diabetic Foot Wound
[ ] Gout
[ ] High Blood Pressure
[ ] Heart Disease
[ ] High Cholesterol
[ ] Other: _____
[ ] Kidney Problems
[ ] Liver Disease or Hepatitis
[ ] Phlebitis
[ ] Rheumatic Fever
[ ] Shortness of Breath
[ ] Sleep Apnea
[ ] Stroke or Heart Attack
[ ] Thyroid Disease
[ ] Ulcer or Gastritis
[ ] Other: _____

Family History:
[ ] Arthritis
[ ] Cancer
[ ] Diabetes

Family Member: _____ (Mother/Father/Sibling)
[ ] High Blood Pressure
[ ] Gout
[ ] High Cholesterol
[ ] Heart Disease
[ ] Stroke or Heart Attack
[ ] Chest Pain or Angina

Tobacco Use: [ ] Yes [ ] No [ ] Quit Years Smoked: _____

Surgeries: _____

Hospitalizations: _____

Family Physician: _____ Ph.: (_____) _____ Last Visit Date: _____

Are you now, or have you been under any other doctor's care for any reason over the past two years?

[ ] Yes [ ] No If Yes, please explain: _____

_____

Current Medications: _____

_____

Pharmacy Name: _____ Pharmacy Phone: _____

Allergies:

[ ] Pain Meds
[ ] Adhesive/Tape
[ ] Penicillin
[ ] Other: _____
[ ] Aspirin
[ ] Codeine
[ ] Seafood
[ ] Iodine
[ ] Demerol
[ ] Sulfa
[ ] Local Anesthetics
[ ] Novocaine
[ ] Steroid

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures such as may be deemed necessary in the diagnosis and treatment of my feet and/or ankle.

_____ _____
Patient Signature Date

1701 East Thomas Road, Suite 201, Phoenix, AZ 85016

Office: 602-251-3113 • **phxfoot.com** • Fax: 602-251-3114

PHOENIX FOOT & ANKLE ASSOCIATES, PC

PATIENT PRIOR AUTHORIZATION POLICY

It is the responsibility of our insured patients to be aware of any restrictions or requirements stated in their insurance policy. This includes deductibles, second opinions, policy exclusions or waived benefits, precertification, inpatient vs. outpatient benefits, and restrictions regarding pre-existing conditions.

As a COURTESY, our office policy is to contact your insurance company for pre-authorization. However, a pre-authorization issued by your insurance company simply means that they agree that your office visit, medication, surgery, physical therapy or orthotics is medically necessary, though they can reverse this decision once the claim is received. This is a standard disclaimer that all insurance companies tell us when we obtain prior authorization for your medical need. What this means is that:

Prior-authorization or pre-certification does NOT guarantee payment from your insurance company. The patient is ultimately responsible.

Your insurance benefits and the payment we receive are determined by the limits your insurance carrier sets.

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE BENEFITS AND LIMITS.

A deposit may be required, if you have not met your deductible or out of pocket expense.

Also, for those patients requiring pre-operative testing, such as blood work, EKG, chest x-ray, etc., these tests may not be approved by your insurance (such as Medicare) and therefore may not be covered by your insurance. You will be responsible if this applies to you.

By signing below, I understand that I am responsible for the charges not covered by my insurance.

_____	_____	_____
PRINT PATIENT NAME	PATIENT/GUARANTOR SIGNATURE	DATE

PHOENIX FOOT & ANKLE ASSOCIATES, PC

RELEASE OF INFORMATION AUTHORIZATION
ASSIGNMENT OF BENEFITS FOR MEDICAL PAYMENT OF SERVICES

Authorization for Release of Information: I authorize Phoenix Foot & Ankle Associates, PC to disclose all or any part(s) of the patient's medical record to listed insurance companies and any agency conducting reviews concerning Worker's Compensation care.

Medicare Patient's Certification: I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request payment be made directly to the provider of services on my behalf and I authorize said provider to release any and all information necessary regarding the treatment and services provided as stated below.

Assignment of Benefits: I hereby authorize payment directly to Phoenix Foot & Ankle Associates, PC by my insurance company(s). In the event an overpayment is made from more than one insurance company, I understand the overpayment will be sent to the appropriate payer.

Insurance: Phoenix Foot & Ankle Associates, PC will file your insurance as a service to you. If our office does not hear from your insurance company within 60 days, we will request your help in contacting your insurance company to resolve the payment delay. The insurance plan is a contract between you and your insurance company. We must hold you responsible for any balances due.

Payment of Services: I understand that I am financially responsible for all charges and fees related to the services rendered to me by Phoenix Foot & Ankle Associates, PC. I further understand that payment in full is expected upon receipt of the first statement which may include co-payments, deductibles, and any services not covered by my insurance. I also understand that I am financially responsible for any charges not covered by my insurance. I hereby assign to Phoenix Foot & Ankle Associates, PC all benefits I am entitled to receive from any person, insurance company, or entity to the extent of medical charges incurred by the patient or me and authorize payment of such benefits directly to Phoenix Foot & Ankle Associates, PC. In the event my account is referred to a collection agency, I will be responsible for collections costs, including interest and reasonable attorney fees.

Health Insurance Portability and Accountability Act (HIPAA): I acknowledge that a copy of the HIPAA Notice of Privacy Practices was made available to me. I was given the opportunity to view a copy of the Notice, which describes how health information about me may be used, disclosed, and how I can get access to this information. If you complete forms prior to your office visit, please see front desk upon arrival to obtain a copy of this document.

Completion of Medical Forms: I understand that Phoenix Foot & Ankle Associates, PC will complete medical forms on my behalf within 4 days, including FMLA forms, at an upfront cost of $10 for a one page document or $25 for multiple pages.

Valuables: I (we) understand that Phoenix Foot & Ankle Associates, PC is not responsible for valuables and personal property brought to the facility.

I further acknowledge and grant to Phoenix Foot & Ankle Associates, PC a lien pursuant to A.R.S. Section 33-932, et seq. against any recovery by me or any person on my behalf made against any liability, uninsured/underinsured motorist or other form of coverage or indemnity, or against a person or entity legally responsible for the medical charges incurred to the extent such charges are not paid in full by other available insurance for by me. Phoenix Foot & Ankle Associates, PC and I also waive any attorney's fees or collection costs associated with the collection of medical charges pursuant to the lien herby granted.

I CERTIFY I HAVE READ AND FULLY UNDERSTAND ALL OF THE ABOVE INFORMATION TO INCLUDE THE CONSENT FOR TREATMENT, RELEASE OF INFORMATION, INSURANCE AUTHORIZATION, & ASSIGNMENT AND PAYMENT OF SERVICES.

_____	_____	_____
PRINT PATIENT NAME	PATIENT/GUARANTOR SIGNATURE	DATE

PHOENIX FOOT & ANKLE ASSOCIATES, PC

NOTICE TO PATIENTS

Dr. J. Timothy Harlan's Patient,

State law, A.R.S. 32-1401 (27)(ff), requires that a physician notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. (I/We) support this law, because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised that (I/We) have a direct financial interest in a diagnostic or treatment agency or in the non-routine goods or services named below. Further, as indicated below, goods or services that (I/We) have prescribed are available elsewhere on a competitive basis.

DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:

____Biltmore Surgery Center_____SurgiCenter_____

ARE THESE SERVICES AVAILABE ELSEWHERE ON A COMPETITIVE BASIS?

__X__ Yes _____ No

IF YES, WHICH ONES:

Banner University Medical Center Phoenix Baptist Hospital_____

In compliance with the requirements of the Federal Government, you are being advised that I have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services named below. Further, as indicated below, goods and services that I may recommend may be available elsewhere on a competitive basis. I would encourage your questions regarding these relationships as we work together to achieve the best care for you.

DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:

_____N/A_____

*INDICATES THAT I HAVE RECEIVED REIMBURSEMENT APART FROM MY CONTRACTUAL RELATIONSHIP

The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. (I/We) will keep the signed original in your patient file and you may receive a copy upon request.

ACKNOWLEDGMENT: (I/We) have read this Notice to Patients form and understand the disclosures that it contains.

_____ _____ _____

PRINT PATIENT NAME PATIENT/GUARANTOR SIGNATURE DATE