DEMOGRAPHICS

Last Name___________________________ First Name ___________________________ Middle Initial____________________

Street_______________________________________ City_______________________ State____________ Zip _____________

SSN __________________________ DOB____/_____/______ Male / Female

Home Phone _________________________________ Cell Phone __________________________

Work Phone __________________________________ E-Mail ____ ☐None

How would you like appointment reminders: Text Phone E-mail None

Employer _______________________________________ Occupation ____

Primary Care Provider (Family Physician) ____

Pharmacy ____

How did you hear about our office? ____

____

Emergency Contact / Guardian:

Last Name___________________________ First Name ___________________________ Middle Initial____________________

Street_______________________________________ City_______________________ State____________ Zip _____________

Home Phone _________________________________ Cell Phone __________________________

Work Phone __________________________________ E-Mail ____

Assignment of Benefits / Release of Billing Information

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed below for any equipment or services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

Consent for Treatment

Please Read and Sign - I hereby give my permission to the doctors of Prairie Foot and Ankle, PC to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot or ankle condition. I hereby authorize my insurance benefits to be paid directly to Prairie Foot and Ankle, PC and the release of any information required by third party payors in claim processing and understand that I am financially responsible for any remaining balance.

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Signature (Patient or Responsible party) Date

Date ____________________

Last Name ____________________ First Name ____________________

Middle Initial ____________________ Date of Birth ____________________

Podiatry History (Please Print)

Primary reason for today's visit: ____

____

____

Which side: Left | Right | Both **Rate your pain on a scale of 1–10** (1 is no pain): __________

Have you been to a podiatrist before? Yes | No **If yes, Dr.** ____________________ **Last Seen** ____________________

Is this a work related injury? Yes | No **If yes, has your employer been notified?** Yes | No

Allergies

☐ **Check if no known allergies**

Allergy	Yes	Reaction
Adhesive/Tape		
Aspirin		
Codeine		
Iodine		
Latex		
Lidocaine		
Penicillin		
Shell Fish		
Sulfa Drugs		
Contrast Dye		
Other:		

Current Medications

☐ **See attached list OR List medications and dosage below**

Medication	Dosage

Medical History

Conditions you have NOW or in the PAST

Problem	Yes	Problem	Yes	Problem	Yes
Anxiety		Heart Attack		Psoriasis	
Arthritis		Heart Disease		Psychiatric	
Asthma		Hepatitis (A B C)		Pulmonary Embolism	
Cancer (specify below)		High Blood Pressure		Rheumatoid Arthritis	
Diabetes (type I or II)		High Cholesterol		Seizure Disorders/ Epilepsy	
Emphysema		HIV/AIDS		Stomach Ulcer	
Fibromyalgia		Kidney Disease		Stroke/ TIA	
GERD (acid reflux)		Mitral Valve Prolapse		Thyroid Disorder	
Other:					

Date ______________________

Previous Surgeries

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____

____

Social History

	Yes	No	Former	Current Employment Status	Yes	No
Drink Alcohol				Are you currently employed?		
Use Illegal Drugs				How many hours do you stand at work (daily)?		
Tobacco Use						

Family History

Condition	Yes	Relationship	Condition	Yes	Relationship
Diabetes					
Heart Disease					
Foot Problems					

Review of Systems

Symptoms you are currently experiencing

Symptom	Yes	Symptom	Yes	Symptom	Yes
Back Pain		Fatigue		Numbness/Tingling	
Bleeding Problems		Fever		Ringing in the ears	
Chest Pain		Headaches/Migraines		Skin Problems	
Chills		Heartburn/Indigestion		Swelling	
Difficulty Breathing		Joint Discomfort/Pain		Urinary Problems	
Dizziness		Muscle Pain		Excessive Weight Gain	
Eye/Vision Problems		Nose Bleeds		Excessive Weight Loss	
Other:					

Consent for Treatment

I certify that all the above information is true and correct to the best of my knowledge. I give permission to the doctor and his/her assistants to administer and perform such procedures as may be deemed necessary the diagnosis and/or treatment of my podiatric condition(s).

____
Signature of Patient or Authorized Representative

____
Date

<u>Prairie Foot and Ankle</u>
<u>Financial Policy – Receipt of Privacy Policy - Assignment of Benefits – Release of Billing information</u>

As a patient of Prairie Foot and Ankle, you are required to sign a financial responsibility and authorization for treatment form. We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of the Policy is important to our professional relationship.

<u>FORMS OF PAYMENT</u>: We accept Cash, Checks, Visa, MasterCard and Care Credit. A returned check fee of $35.00 per check returned from your bank for non-payment or insufficient funds is assessed to your account.
<u>COPAYMENTS</u>: Your insurance REQUIRES that we collect your designated co-pay <u>at the time of service</u>. Please be prepared to pay the co-pay at each visit.
OUTSTANDING BALANCES: All outstanding balances are the responsibility of the patient. (After we have received payment from your insurance company). If you are unable pay your balance in full, please contact the billing department to arrange a payment plan. We expect balances to be paid within 1 year. Chronic non---payment of your outstanding balances can constitute your balance being turned over to collections and/or severance from the Practice.
ESTIMATED SURGICAL DEPOSITS: Should you decide or require surgery, you are responsible for all fees, such as co---pays, co---insurance, deductibles or out---of---pocket expenses for our surgeon's fee, which your insurance company makes you responsible for. Our practice may require a 50% deposit for the physician fees prior to your surgical procedure. Our office will contact you with information pertaining to the amount you are responsible for. Please note; our fees are separate from the hospital or ambulatory surgical center, and the anesthesiologist. Additional questions should be directed to your insurance company. Refusal to pay these fees can result in rescheduling or cancellation of your surgery.
<u>INSURANCE</u>: As a courtesy to our patients, we accept most Insurances. This medical office will prepare any and all necessary reports and itemization to assist in making collections of claims from insurance companies and will credit any such collection to your account. However, Prairie Foot and Ankle cannot render services under the assumption that its charges will be paid by insurance companies. You are personally responsible for payment of services rendered. Prairie Foot and Ankle will submit a claim to your insurance on your behalf. A determination will be made by your insurance carrier. You will be responsible for any expenses as determined by your insurance provider. Some items and services will not be covered and you will be responsible for 100% of that cost. If you have any questions, please contact the billing department. If you elect to be treated by a physician or any provider at Prairie Foot and Ankle who does not participate with your insurance plan, you will be directly responsible charges and fees, and may not be reimbursed by insurance. Further, I am responsible for services or items not covered by my insurance plan, such as DME (durable medical equipment), over the counter items, or Orthotic devices. By signing this agreement, you understand and agree that should the insurance company fail to remit payment to Prairie Foot and Ankle, you are individually obligated to pay any outstanding balance due to Prairie Foot and Ankle. It is your responsibility to notify the organization of any changes in my health care coverage. YOU UNDERSTAND THAT BY SIGNING THIS FORM YOU ARE ACCEPTING FNANCIAL RESPONSIBILITY AS EXPLAINED ABOVE FOR ALL PAYMENT FOR PRODUCTS RECEIVED.
<u>ASSIGNMENT OF BENEFITS</u>: In return for the services rendered to you, you hereby authorize direct payment to Prairie Foot and Ankle of any insurance or health plan benefits and/or claims otherwise payable to or on behalf of you for professional services rendered during this office visit including emergency services if rendered. In the absence of such payment, Prairie Foot and Ankle is further assigned all necessary rights to collect such benefits and/or payments. You authorize Prairie Foot and Ankle, or the billing department, to represent you in any appeal process or claim denial appeal in order to collect payment from the appropriate insurance company and/or responsible party. You understand that you are financially responsible for charges not covered by this assignment.
<u>RELEASE OF BILLING INFORMATION</u>: You agree that to the extent necessary to determine responsibility for payment, to determine benefits or benefits payable, or to obtain reimbursement, Prairie Foot and Ankle may disclose and/or release a portion or all of your record, including my medical record, to any person or entity that is or may be responsible for all or any portion of the office and/or physician charges, including but not limited to insurance companies, health care service plans, workers compensation carriers, medical or utilization review organizations, Medicare (if you are a Medicare beneficiary), the Health Care Financing Administration, or any other person or entity as necessary in connection to such payment or reimbursement. If you are a Medicare beneficiary, you certify that the information given by you in applying for payment under the Social Security Act is correct, and you authorize release of any information needed to act on this request.
<u>CONSENT FOR TREATMENT</u>: You hereby voluntarily consent to the diagnosis, treatment, care, examinations and/or procedures which may be performed on you during your visit to Prairie Foot and Ankle. You hereby voluntarily authorize Prairie Foot and Ankle and its physicians, fellows, visiting residents, and/or technicians to perform on you any and all diagnoses, treatment, care, examinations and/or procedures for your health condition(s).
<u>REFERRALS</u>: If your insurance plan requires a referral from your primary care physician it is <u>YOUR</u> responsibility to obtain the referral prior to your appointment and to have it with you at the time of the appointment. If you do not have your referral, **you may have to reschedule your appointment.**
<u>ACCIDENT/WORKERS COMP CASES</u>: You shall be financially responsible for medical services related to accident/workers comp which are denied. You must notify Prairie Foot and Ankle of the date of injury, claim number, insurance company address, phone number, and contact person's name prior to coming to the office. If Worker Compensation is denied, and you have private health insurance, they may be billed. We will require, for this reason, your private insurance information. If neither Comp nor private insurance pays, you are responsible for payment.
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: You acknowledge that you have received and reviewed a copy of Prairie Foot and Ankle's Notice of Privacy Practices. This acknowledgment recognizes that you have been informed of your privacy rights under HIPAA.

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Patient Name (Please Print)

____ _________________________
Patient Signature (or Representative/Guarantor) Date

Prairie Foot & Ankle

Cancellation and No-Show Policy

When an appointment is scheduled, that time is reserved exclusively for you to discuss and manage your healthcare needs. We understand that unforeseen circumstances may arise in which you must cancel your appointment. We request that you provide us with at least 24 hours notice of cancelations so that we can have adequate time to offer this appointment to a patient on our wait list.

Office appointments that are canceled with less than 24 hours notification will be subject to a $20.00 fee. This charge is the responsibility of the patient and will need to be paid in full prior to the next appointment.

We understand that special, unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived on a case-by-case basis at the sole discretion of management.

Prairie Foot & Ankle understands that a therapeutic provider/patient relationship is based on understanding, good communication, and mutual respect. Questions about cancellation policy should be directed to the clinic manager at 308-646-0077.

Dragon Ambient eXperience Consent

Healthcare providers today spend a significant amount of time on computers documenting care, which takes away from their ability to spend time focused on patient's. To support our mission of providing high-quality care, we are using a technology which uses artificial intelligence and associated workflows to generate documentation based on recorded audio of patient visits. This technology significantly reduces the amount of time your provider spends on documentation and allows more time for providing care to you and other patients. We use a third-party service provider to process the audio recordings and generate our clinical documentation and we have appropriate agreements in place to ensure confidentiality of your information. All documentation is reviewed, edited if necessary, and approved by your provider, prior to finalization, to ensure the accuracy and completeness of your medical record. We ask for you to sign this form to indicate your consent to have your visit recorded and processed, in this manner, for the purpose of documenting your care. I hereby consent to the recording of my visit today as well as any future visits. I understand that I may revoke consent to the recording of future visits at any time.

I have read and agree to the above policies:

Patient or Representative

Signature____ Date________________

Relationship to patient: ______________________________