

IDAHO FOOT & ANKLE ASSOCIATES

PATIENT INFORMATION

Patient's Name _____
Last First Middle Initial
Address _____
Street City State Zip
Date of Birth ___/___/___ **Age** ___ **Social Security #** _____
Gender: (M / F) **Marital Status:** (Single / Married / Divorced / Widowed)
Home Phone _____ **Cell Phone** _____ **Work Phone** _____
Email _____ **Contact Preference:** Email Phone Postal Txt

Ethnicity	Race	Preferred Language
<input type="checkbox"/> Unspecified	<input type="checkbox"/> Unspecified	<input type="checkbox"/> English
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> White	<input type="checkbox"/> Spanish
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Other _____
<input type="checkbox"/> Unknown	<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> Unspecified
	<input type="checkbox"/> Black or African American	

Employer _____ **Occupation** _____
Address _____
Street City State Zip
Who to contact in an emergency:
Name _____ **Relation** _____ **Phone #** _____

If the patient is a minor, please complete this section:

Parent/Guarantor Name _____
Address _____
Street City State Zip
Date of Birth ___/___/___ **Age** ___ **Social Security #** _____
Home Phone _____ **Cell Phone** _____ **Work Phone** _____

How did your hear of our clinic? Physician / yellow pages / website / radio / insurance / friend
Primary Care Physician _____ **Phone** _____
Referring Physician _____ **Phone** _____

Primary Insurance Company _____
Subscriber Name _____ **Date of Birth** ___/___/___
Address _____ **City** _____ **State** _____ **Zip** _____
Policy # _____ **Group #** _____ **Employer** _____
Patient's relationship to the policyholder: Self / Spouse / Dependent

Secondary Insurance Company _____
Subscriber Name _____ **Date of Birth** ___/___/___
Address _____ **City** _____ **State** _____ **Zip** _____
Policy # _____ **Group #** _____ **Employer** _____
Patient's relationship to the policyholder: Self / Spouse / Dependent

All Patients, Please Read & Sign:

I authorize payment of medical benefits from Medicare, Medigap, private and/or group insurance be made on my behalf to Idaho Foot & Ankle for any services or supplied furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration or my insurance company any information needed to determine benefits for related services. I also take responsibility for payment of charges, regardless of payment or denial of payment from my insurance company.

Signature of Patient/Guarantor

Date

NAME:

AGE:

DATE OF BIRTH:

BRIEF MEDICAL HISTORY

Describe your foot problem:

Shoe Size:

Preferred Pharmacy:

ACCIDENT/INJURY RELATED? YES NO IF YES, IS IT WORK RELATED? YES NO

DATE OF INJURY?

PAST MEDICAL HISTORY: Do you have a history of any of the following?**ARE YOU PREGNANT?** Yes No

<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Headache	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Psychiatric Disorder
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hearing Disorder	<input type="checkbox"/> Liver Disease		<input type="checkbox"/> Sciatica
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> COPD	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> MRSA		<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer Type:	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Nerve Disorder		<input type="checkbox"/> Thyroid Problem
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Osteoporosis		<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> DVT	<input type="checkbox"/> Vascular Disease
<input type="checkbox"/> Gout	<input type="checkbox"/> Keloid/Thick Scar	<input type="checkbox"/> Poor Circulation		

PLEASE LIST ALL MEDICATION NOW BEING TAKEN	NONE <input type="checkbox"/>	DOSE	ALLERGIES	
			<input type="checkbox"/> NSAIDS	<input type="checkbox"/> Aspirin
			<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa drugs
			<input type="checkbox"/> Novocain	<input type="checkbox"/> Anesthesia
			<input type="checkbox"/> Codeine	<input type="checkbox"/> Sedatives
			<input type="checkbox"/> Iodine	<input type="checkbox"/> Adhesives
			<input type="checkbox"/> Latex	<input type="checkbox"/> NONE
			<input type="checkbox"/> Other	

PREVIOUS SURGERIES	NONE <input type="checkbox"/>	Year	Surgeon/Hospital

FAMILY HISTORY PLEASE INDICATE: F=FATHER M=MOTHER S=SIBLING		SOCIAL HISTORY	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Foot Problems	Occupation:	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Attack	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
<input type="checkbox"/> Stroke	<input type="checkbox"/> High Blood Pressure	Tobacco	<input type="checkbox"/> No <input type="checkbox"/> Yes Amount:
<input type="checkbox"/> Cancer	<input type="checkbox"/> Birth Defects	Alcohol	<input type="checkbox"/> No <input type="checkbox"/> Yes Amount:

REVIEW OF SYSTEMS Please check if you have any of the following			
GENERAL	RESPIRATORY	MUSCULOSKELETAL	PSYCHIATRIC
<input type="checkbox"/> Fever	<input type="checkbox"/> Cough	<input type="checkbox"/> Pain	<input type="checkbox"/> Depression
<input type="checkbox"/> Chills	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Muscles <input type="checkbox"/> Neck	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Fatigue	CARDIOVASCULAR	<input type="checkbox"/> Back <input type="checkbox"/> Hips	ENDOCRINE
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Knees <input type="checkbox"/> Ankles <input type="checkbox"/> Feet	<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Chest Pain (Angina)	<input type="checkbox"/> Limited Range of Motion	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Abnormal Heart Beat	<input type="checkbox"/> Limited Strength	<input type="checkbox"/> Frequent Thirst
SKIN	<input type="checkbox"/> Cold Extremities	<input type="checkbox"/> Leg Cramps	<input type="checkbox"/> Heat <input type="checkbox"/> Cold (Intolerance)
<input type="checkbox"/> Rash	<input type="checkbox"/> Poor Circulation	NEUROLOGICAL	HEMATOLOGICAL
<input type="checkbox"/> Itching	GASTROINTESTINAL	<input type="checkbox"/> Headache	<input type="checkbox"/> Blood Thinners
<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting	<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Toenail/Fingernail Changes	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting	<input type="checkbox"/> Seizures	<input type="checkbox"/> Blood Abnormalities
<input type="checkbox"/> Foot Sores or Skin Lesions	<input type="checkbox"/> Heartburn <input type="checkbox"/> GERD	<input type="checkbox"/> Numbness	<input type="checkbox"/> Enlarged Lymph Nodes

ANY PROBLEMS NOT LISTED

SIGNATURE

DATE



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2947 E. Magic View Ste., #2 • Meridian, ID 83642 • 208-888-9876
2635 Caldwell Blvd., Ste 101 • Nampa, ID 83651 • 208-463-1660

Idaho Foot & Ankle Associates
"Gold Standard in Foot and Ankle Care"

◆ Kerry Anderson, D.P.M. ◆ Ryan Kemp, D.P.M. ◆ Adam Gerber, D.P.M. ◆ Boyd Andrews, D.P.M. ◆

CAREQUALITY TREATMENT CONSENT

I hereby consent to and authorize Idaho Foot and Ankle Associates to share my health data with other organizations through the Carequality platform, so that a wide network of providers will be able to treat me when I need services outside of Idaho Foot and ankle. I understand that Idaho Foot and Ankle and Carequality will transmit my data securely to protect my privacy.

Signature: _____ **Date:** _____



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DIAGNOSTIC TESTING

The physicians at Idaho Foot & Ankle Associates are committed to superior care and may need to provide additional testing during your visit.

In order to accurately diagnose and treat your problem with the best standard of care, your physician may prescribe diagnostic tests such as x-rays.

Each insurance policy processes these differently and charges may be applied to your deductible and/or co-insurance. Every effort will be made to obtain any authorization needed prior to your x-rays.

I understand all diagnostic testing is provided at an additional cost. If you wish to discuss charges prior to testing please ask to speak with the billing staff.

Signature: _____ **Date** _____



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Patient Financial Policy and HIPAA Acknowledgement

This is an agreement between Idaho Foot & Ankle Associates and the Patient/Guarantor named below. By signing this agreement, you acknowledge that you understand our insurance and financial policies and agree to pay for all services received.

Initial Visit: Please provide us with your insurance card and billing information if you would like us to bill your insurance for you. Otherwise, payment in full will be required at the time of your visit. It is important that you inform us of any changes to your address, telephone number or insurance coverage. You can reach our billing department at (208)375-6454.

Health Insurance: Idaho Foot & Ankle Associates is contracted with several managed care plans and private insurance. If you have multiple insurance coverages, please inform us. As a service, we will bill your insurance company. However, you are responsible at the time of the visit for any copayment, coinsurance, deductible, out-of-pocket expenses, or charges not covered by your insurance company, including over-the-counter supplies.

It is your responsibility to know your insurance benefits and limitations. If you need a special item or service, we will provide you with the necessary code and description to confirm benefit information with your insurance company.

Balances on your statement are due upon receipt. Failure to pay may result in restrictions on future appointments and collection proceedings. All returned checks will incur a \$20 returned check fee.

Assignment of Benefits: I hereby authorize my insurance benefits to be paid directly to Idaho Foot & Ankle Associates for services rendered. I understand and agree that:

1. I am financially responsible for any copayments, coinsurance, deductibles, or charges not covered by my insurance plan.
2. Idaho Foot & Ankle Associates may submit claims and release necessary medical or account information to my insurance company or its representatives to process claims for services provided.
3. This Assignment of Benefits applies to all current and future claims unless revoked in writing.

Medicare Patients: If you are a Medicare patient, Idaho Foot & Ankle Associates is a Medicare Participating Provider. We accept assignment and will bill Medicare on your behalf. Your responsibilities include:

- Payment for any deductible and coinsurance amounts.
- Payment for charges not covered under the Medicare program.
- Completion of an Advanced Beneficiary Notice form for services that may not be covered, before those services are provided.

Surgery Estimate and Prepayment: If surgery is required, we will provide an estimate of fees as part of the pre-operative process. Actual charges may differ. Prepayment is due at your pre-operative appointment as follows:

- Health Insurance Plans: Unmet deductibles and estimated copays.
- Self-Pay Patients: One-third of the estimated fees.



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Payment Options: You may pay using one of the following methods:

1. In Full: Cash, check, or credit card.
2. Three Equal Payments: Paid within 90 days from the date of service.
3. Extended Payment Plans: Payments extending beyond 90 days will be referred to an outside agency and subject to a setup fee and interest.

Interest Charges: Starting January 1, 2020, interest will accrue on all unpaid balances at a rate of 2% beginning 30 days from your first statement date.

Idaho Patient Act: The Idaho Patient Act requires that health care providers provide a "Consolidated Summary", in writing, that provides names and contact information of other entities that may bill you as part of your services received by Idaho Foot & Ankle Associates. Please remember that if you are referred to an outside provider or facility for services (i.e. imaging, labs, surgery, evaluations, physical therapy, consults etc.), these services are handled through those respective billing departments. Please keep this document for your records and contact your insurance companies or these organizations directly with any concerns

Laboratory Services

- o Rocky Mountain Labs (8950 W. Emerald St. STE 158 | Boise, ID 83704 |833-765-5227
- o Interpath Laboratory (2460 SW Perkins Ave. |Pendleton, OR 97801|866-289-4093
- o St. Luke's laboratory (190 E. Bannock St. |Boise, ID 83714|208-706-2333- billing
- o Treasure Valley Laboratory (5475 Bethel St. | Boise, ID 83706| 208-367-6392
- o LabCorp (10555 W Overland Rd |Boise, ID 83709|208-686-7071
- o Bako Diagnostics (6240 Shiloh Rd |Alpharetta, GA 30005|855-245-2256
- o Saint Alphonsus Laboratory (1055 N. Curtis Rd |Boise, ID 83706 | 208-367-2130-billing

I have read, understand, and agree to comply with these policies.
I acknowledge receipt of Idaho Foot & Ankle Associates' Notice of Privacy Practices.

Date: _____

Signature: _____
Patient/Guarantor

Patient Name (Print): _____



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MEDICAL RECORDS POLICY

Idaho Foot and Ankle Associates take pride in keeping an accurate record of your visits. It is standard procedure in the medical field to keep all original records and x-rays as a permanent record of your care. To ensure compliance with regulatory requirements we have a policy in place for the release of records and x-rays. It is the patient's right to have copies of their records, including their x-rays for personal or medical use. If you would like a copy of your records and/ or x-rays, you must complete a HIPAA approved Records Release Authorization provided by our office. A Practice Physician reviews all record and x-ray requests for patient security purposes.

Please give our office 48 hour notice to prepare copies of your medical records and/ or x-rays. Copies of medical records are of no cost to our patients. Copies of the original x-rays are \$5.00 per CD.

Patient Signature: _____

Date: _____



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Over-the-Counter (OTC) Products – Self-Pay Agreement

Please be advised that all over-the-counter (OTC) products offered and purchased through our office are **not billable to insurance**, including Medicare and other third-party payers. By signing this agreement, you acknowledge and agree that you are **electing to self-pay** for any OTC products you choose to purchase from our office.

In accordance with Medicare guidelines, OTC products are considered non-covered items and are therefore your financial responsibility. Your signature below confirms that you have been informed of this policy and that you agree to be personally responsible for payment at the time of purchase.

Print Name

Patient Signature

Date