

# Florida Foot & Ankle Group, P.A.

## PATIENT INFORMATION

(Please Print)

Date \_\_\_\_\_  
Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Sex:  Male  Female  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Home Phone # ( \_\_\_\_\_ ) \_\_\_\_\_  
E-Mail \_\_\_\_\_ Cell Phone # ( \_\_\_\_\_ ) \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone # ( \_\_\_\_\_ ) \_\_\_\_\_  
If Minor, Responsible Party \_\_\_\_\_ Phone # ( \_\_\_\_\_ ) \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone # ( \_\_\_\_\_ ) \_\_\_\_\_  
Primary Physician (full name) \_\_\_\_\_ Phone # ( \_\_\_\_\_ ) \_\_\_\_\_  
Pharmacy (name & location or phone #) \_\_\_\_\_

Marital Status:  single  married  divorced  widowed  none  
Work Status:  employed  student  retired  none  
Referral Source:  doctor  friend/family  phone book  insurance book  other  
Ethnicity:  Hispanic  Non-Hispanic  Declined  
Preferred Language \_\_\_\_\_  Declined  
Race:  White  Black/African American  Asian  Native American  Pacific Islander  Declined

## INSURANCE INFORMATION

Primary Insurance \_\_\_\_\_  
Subscriber \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_  
ID # \_\_\_\_\_  
Group # \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_  
Relationship to Insured \_\_\_\_\_  
Secondary Insurance \_\_\_\_\_



**FLORIDA FOOT & ANKLE GROUP, P.A.**

**Patient Consent For Use and Disclosure of Protected Health Information**

With my consent, **Florida Foot & Ankle Group, P.A.**, may use and disclose Protected Health Information (PHI) about me to carry out Treatment and Payment Operations (TPO). Please refer to the **Florida Foot & Ankle Group, P.A.**, Notice of Privacy Practices (NPP) for a more complete description of such uses and disclosures.

I have the right to review the NPP prior to signing this consent. **Florida Foot & Ankle Group, P.A.**, reserves the right to revise its NPP at anytime. A revised NPP may be obtained by forwarding a written request to: **Florida Foot & Ankle Group, P.A., 925 Williston Park Point, Suite 1009, Lake Mary, FL 32746.**

With my consent, **Florida Foot & Ankle Group, P.A.**, may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results.

With my consent, **Florida Foot & Ankle Group, P.A.**, may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, **Florida Foot & Ankle Group, P.A.**, may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that **Florida Foot & Ankle Group, P.A.**, restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Florida Foot & Ankle Group, P.A.**, to the use and disclosure of my PHI to carry out TPO. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents. I understand that, upon my request, I may view or receive a copy of the information referenced above, and a copy of this form after I sign it.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign the consent, **Florida Foot & Ankle Group, P.A.**, may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Print Name of Patient of Legal Guardian

**SIGNATURE ON FILE FORM**

**FLORIDA FOOT & ANKLE GROUP, P.A.**

**I hereby give consent to Florida Foot & Ankle Group, P.A. to provide whatever treatment the assigned physicians may deem necessary to the patient named below.**

**I understand that I am responsible for payment of services provided to me. I hereby assign insurance benefits, otherwise payable to me, to be paid directly to Florida Foot & Ankle Group, P.A. for Professional Physicians fees and authorize release of information for insurance purposes. I understand I am responsible for charges not covered by my insurance policy and will pay balances in full within 30 days of the first billing statement. A rebilling fee of \$10.00 will be added for each additional billing statement sent. All collection fees incurred by Florida Foot & Ankle Group, P.A. will be my responsibility.**

**I hereby request payment of authorized Medicare benefits and/or any other insurance benefits to be made either to me or on my behalf to Florida Foot & Ankle Group, P.A. for any services furnished me by Florida Foot & Ankle Group, P.A. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable to related services.**

**I understand my signature requests that payment be made and authorizes release of medical information necessary to process the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned claims, 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 services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.**

**Name of Responsible Party: \_\_\_\_\_**

**Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**(Form revised 11/04)**

## **Florida Foot & Ankle Group, P.A.**

### **FINANCIAL POLICY**

*Thank you for choosing Florida Foot & Ankle Group, P.A., as your foot care provider. The following information discusses our current financial policy and procedures.*

1. It is your responsibility to provide accurate demographic and insurance information and a picture ID at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. A copy of our billing form will be provided if requested.
2. If your insurance plan requires a referral, it is your responsibility to obtain the referral prior to being seen by our physicians. Failure to provide a referral may necessitate rescheduling of your appointment.
3. It is your responsibility to ensure that our physicians are in your insurance network.
4. Copayments are due at the time of your visit. Also, co-insurance, unmet deductibles and outstanding balances are due at the time of your visit or prior to scheduled surgeries and procedures. We accept cash, checks and credit/debit cards. Post-dated checks are not accepted.
5. We will bill your insurance company on your behalf. You agree to assign payment to Florida Foot & Ankle Group and authorize Florida Foot & Ankle Group to bill your insurance plan in accordance with your insurance benefits in place at the time services are rendered.
6. Your insurance plan may not cover all services and/or supplies provided to you during your visit. These "non-covered" charges will be your responsibility, and due at the time of your visit or upon receipt of a billing statement.
7. You are ultimately responsible for payment of charges for services you receive from our office and/or physicians .
8. Cancellations for office appointments and procedures must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery must be received at least 2 weeks days prior to the scheduled surgery date.
9. A \$25 no-show fee will be charged to patients who do not cancel or reschedule at least 24 hours before their scheduled appointment. A \$100 fee may be charged for surgeries cancelled less than 2 weeks prior to the scheduled surgery.
10. The returned check fee is \$30.
11. Medical records requests must be received in writing at least one week prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the State of Florida, and must be received prior to record delivery. No more than five pages may be faxed.
12. X-ray copy requests must be received at least one week prior to the date needed. There will be a \$15 fee for each x-ray copied.
13. There will be a prepaid fee of \$20 for completing individual medical leave forms, disability forms, work restriction forms, employer forms, school forms, insurance forms, etc. All form requests require 5 to 7 business days to process.
14. Durable medical equipment (DME) consists of items such as crutches, surgical shoes, and removable casts. Once dispensed, these items cannot be returned or exchanged.
15. Over-the-counter products and medical supplies purchased from our office cannot be returned or exchanged.

**Your signature certifies that you have read the foregoing policy and accept its terms.**

\_\_\_\_\_  
Patient or Patient's Representative or Responsible Party

\_\_\_\_\_  
Date

**ACKNOWLEDGMENT OF RECEIPT  
OF  
NOTICE OF PRIVACY PRACTICES**

**I acknowledge that I have been provided a copy of the Notice of Privacy Practices (see link on website) and that I have read (or had the opportunity to read if I so chose) and understand the Notice.**

\_\_\_\_\_  
**Patient Name (please print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent or Authorized Representative (if applicable)**

\_\_\_\_\_  
**Signature**