Michigan Foot & Ankle Specialists Date: _____

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Other_____
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)	EMPLOYER PHONE	

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ❑spouse ❑parent ❑guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

PRIMARY DOCTOR/FAMILY DOCTOR	REFFERING DOCTOR	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

ASSIGNMENT AND RELEASE : I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

Authorization to release health information to:

Name(s)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	DAYTIME PHONE
DATES OF SERVICE FROM: TO:	AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) ❑ NEVER DATE:		

Release the following information:

❑ All Records ❑ Chart Notes ❑ Radiology Reports ❑ Operative Reports ❑ History & Physicals

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	

Michigan Foot & Ankle Specialists

Date: _____

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

***** Preferred Pharmacy:**

Allergies

- ❑ NONE/No Known Allergies
- ❑ Adhesive Tape
- ❑ Anesthesia
- ❑ Aspirin
- ❑ Codeine
- ❑ Dairy Products
- ❑ Iodine/Shellfish/Contrast Dye
- ❑ Latex
- ❑ Morphine
- ❑ Penicillin
- ❑ Sulfa Drugs
- ❑ Wheat

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ ☐ Retired ☐ Disabled (reason _____)

☐**Yes** ☐**No -** Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic

☐**Yes** ☐**No -** Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

- ❑ NONE of the problems listed
- ❑ allergies
- ❑ anemia
- ❑ arthritis conditions
- ❑ asthma
- ❑ arterial fibrillation
- ❑ bleeding problems
- ❑ BPH
- ❑ CAD coronary artery disease
- ❑ cancer
- ❑ cardiac arrest
- ❑ celiac disease
- ❑ chest pain
- ❑ CHF congestive heart failure
- ❑ chronic fatigue syndrome
- ❑ depression
- ❑ diabetes
- ❑ drug/alcohol abuse
- ❑ erectile dysfunction
- ❑ fibromyalgia
- ❑ Gerd
- ❑ heart disease
- ❑ high cholesterol
- ❑ hyperinsulinemia
- ❑ hyperlipidemia
- ❑ hypertension
- ❑ hypogonadism male
- ❑ hypothyroidism
- ❑ infection problems
- ❑ insomnia
- ❑ irritable bowel syndrome
- ❑ kidney problems
- ❑ menopause
- ❑ migraines/headaches
- ❑ neuropathy
- ❑ onychomycosis
- ❑ organ injury
- ❑ osteoporosis
- ❑ pulmonary embolism/blood clot in legs
- ❑ seizure disorders
- ❑ shortness of breath
- ❑ sinus conditions
- ❑ stroke
- ❑ syndrome X
- ❑ tremors
- ❑ wheat allergy

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PERSCRIBING DOCTOR

Michigan Foot & Ankle Specialists

CREDIT AND PAYMENT POLICY

We are pleased that you have chosen Michigan Foot & Ankle Specialists as your Provider. Our goal is to provide you with the highest level of professional medical care possible, while keeping medical costs to a minimum. In an effort to provide quality medical services, we have established the following credit and payment policies.

If you have insurance:
We submit claims on your behalf to your primary and secondary insurance carriers. If you have questions or concerns about your insurance coverage, please call your carrier. Your insurance contract is between you and your carrier. Any remaining patient balance is due within 10 days of the date you receive your statement.

Non-Covered Services:
Payment in full is required at the time of treatment for services not covered by your insurance. Co-payments: Co-payments are due at the time of service. If you are unable to pay, your appointment may be rescheduled.

Medicare:
Michigan Foot & Ankle Specialists accepts Medicare assignment. We will submit your claim directly to Medicare and will bill your secondary insurance after Medicare has paid their portion. You are responsible for any allowed amount that is not paid by Medicare and/or your secondary insurance. Any remaining patient balance is due within 10 days of the date you receive your statement.

Michigan Health Plans:
To receive treatment, you must currently be covered by the Michigan Health Plans. You must be assigned to a health plan this clinic participates with. Proof of coverage is required at each time of service.

Workers Compensation:
Please notify the registration desk at each appointment if your visit is due to an injury covered by Workers Compensation. To file a Workers Compensation claim, you will need the name of your worker's compensation insurance carrier, the date of your injury, the name and address of your employer at the time of the injury, and the claim number (if available). If you have questions or concerns about your insurance coverage, please call your carrier. We cannot accept responsibility for negotiating a disputed claim.

Motor Vehicle or Other Liability Claims:
Pacific Medical Group, P.C. requires payment within 30 days from the date of service, for visits related to motor vehicle/personal liability injury. The patient is required to provide accurate complete billing information at the time of service when applicable.

Michigan Foot & Ankle Specialists requires a $50.00 deposit at the time of service for each visit regarding a motor vehicle accident or personal liability injury.

In the event that your claim is disputed or a suit is established against another party, Michigan Foot & Ankle Specialists cannot accept the responsibility of collecting on these cases or negotiating settlements. Patients will be asked to work with our business office to establish a suitable payment plan to pay the balance of your medical charges. While we understand that settlement of these cases can take months, we do not feel that suit against another party is reason for non-payment of your medical charges.

If you do not have insurance:
We require self-pay (uninsured) patients to pay a deposit at time of treatment. In circumstances where unexpected major medical expenses are incurred, we will help you arrange a payment schedule.

Broken and Canceled Appointments:
Our clinic requests that you notify us 24 hours in advance when canceling a scheduled appointment. We reserve the right to charge a fee for any appointment canceled or broken without reasonable notice.

Financial Responsibility:
Patients are financially responsible for all services rendered. If you are required to pay for treatment at the time of service, but are unable to do so, your appointment may be rescheduled. A fee will be assessed for checks returned for insufficient funds. Failure to meet financial responsibility will result in legal action.

Effective January 1, 2017, a rebilling charge of $5 will be added to all accounts with unpaid patient responsibility balances over 60 days.

Exceptions to these policies will not occur unless you make prior arrangements with our business office.

Agreement:
I have read and understand the Michigan Foot & Ankle Specialists Credit and Payment Policy. My signature below indicates that I accept this policy and agree to abide by the terms for my treatment with Michigan Foot & Ankle Specialists.

PRINT PATIENT NAME	Patient Signature or Legal Guardian, if patient a minor	Date

Michigan Foot & Ankle Specialists

ACKNOWLEDGMENT AND CONSENT

I understand that Michigan Foot & Ankle Specialists (referred to below as "MFAS") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that MFAS may **use and disclose** my health information in order to:

·Make decisions about and plan for my care and treatment;

·Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;

·Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and

·Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how MFAS will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of MFAS, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I

am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of MFAS's Notice of Privacy Practices in effect will be posted in waiting/reception area and will be posted on the MFAS website at the following address: http://www.MiFootAnkle.com.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that MFAS is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____ **Date:** _____

_____

(Print name)

OR

By: _____ **Date:** _____

(Patient representative)

Description of Representative's Authority: _____