

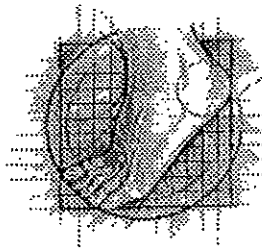


Foot and Ankle Associates of Florida

Medicine and Surgery of the Foot and Ankle

PLEASE PRINT LEGIBLY						
Patient's First Name/Middle Int.		Last Name		Sex	Marital Status	Date
Residential Address		City		State		Zip Code
Mailing Address (if different from above)		City		State		Zip Code
Date of Birth	Age	Patient's Social Security Number		Emergency Contact Person and Phone Number		
Home Phone	Cell Phone		*Email Address		Employer	
How were you referred to us?				Work Phone Number		
*Guarantor's Name (if patient is a minor)		Guarantor's SSN		Relationship to Patient		
INSURANCE INFORMATION						
Primary Insurance Name			Secondary Insurance Name (if applicable)			
Name of Primary Subscriber			Name of Primary Subscriber			
Subscriber's Birthdate		Policy Number		Subscriber's Birthdate		Policy Number
MEDICAL INFORMATION						
List any medical conditions you have (allergies, impairments, etc.)						
List any medications you are currently taking (include birth control if applicable)						
*Pharmacy Name AND Phone Number (or Address)						
Name of Primary Care Physician		Phone Number		If your injury was due to an accident, was it work-related or auto-related? Yes or No		
Reason for your visit today						
I hereby give Foot and Ankle Associates of Florida permission to examine and treat me. I also authorize the release of any medical information necessary to process my claims. I hereby request payment of any insurance or 3rd party benefits that I am entitled to, be made directly to Foot and Ankle Associates of Florida for any services furnished to me during the course of my treatment.						
Patient's (or Guardian's) Signature _____ Date _____						

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Request for Confidential Communication of Protected Health Information

I, _____,

Patient Name (Please Type or Print)

hereby request and authorize that confidential communication of protected health information be disclosed to the following individual.

Name Relationship

Telephone Number

Name Relationship

Telephone Number

Name Relationship

Telephone Number

Name Relationship

Telephone Number

Patient Name (Signature)

(Date)

Foot and Ankle Associates of Florida

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by **Foot and Ankle Associates of Florida** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Foot and Ankle Associates of Florida may or may not agree to restrict the use or disclosure of your protected health information.

If **Foot and Ankle Associates of Florida** agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

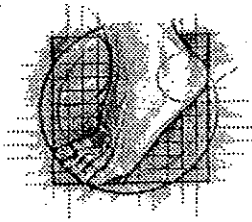
Foot and Ankle Associates of Florida reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to **Foot and Ankle Associates of Florida** to use and disclosure my health information in accordance with it.

Name of Patient (Print or Type)

Signature of Patient



Foot and Ankle Associates of Florida

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Financial Policy

Thank-you for choosing Foot & Ankle Associates of Florida. We are committed to providing you with the best possible care. If you have medical insurance, we would like to help you receive your maximum allowable benefits. The following information is provided to help understand this process and alleviate any misunderstanding that could occur concerning payment for professional services:

- ❖ We need to be certain that we have accurate information from you in order to process your claim correctly.
- ❖ Please be aware that some services may be considered non-covered by your insurance company as there are many different plans available, and not all plans cover all services. It is important that you become familiar with your plan and the coverage that you have available to you.
- ❖ We believe that the choice for medical treatment should be yours, and should you choose to receive treatment in our office for any service or product not covered by your insurance company, that you agree to be responsible for payment of these charges.
- ❖ You are also responsible for any deductible, co-insurance and/or co-payment as stated in your plan, and this is due on the day of service.
- ❖ *Your insurance plan is a contract between you and the insurance company* and we file claims to your insurance as a courtesy to you.
- ❖ In most cases, we will accept assignment of insurance benefits. What we charge is usual and customary for our area. You are responsible for full payment regardless of any insurance company's arbitrary determination of usual and customary rates. Estimated deductible and co-payments are due on date of service.
- ❖ By law, your insurance carrier must remit payment or deny your claim within 30 days of initial notice of claim. We may need you to assist us in contacting your insurance carrier to resolve an insurance problem should one arise as we feel it is necessary to work together to resolve any insurance problem.
- ❖ Should your insurance company determine a service as "non-covered", you will be held responsible for all unpaid balances.

- ❖ *We accept CASH, Checks, Travelers checks, Visa, MasterCard, Discover and American Express.*
(Our fee to copy Medical Records is: \$1.00 per photocopied page; \$10.00 per x-ray film duplication)

We understand that temporary financial problems may affect timely payment of the balance of your account. If such problems arise, we encourage you to contact our billing office for assistance in the management of your account. (321-207-2839)

I have read and understand the above financial policy of Foot & Ankle Associates of Florida, and agree to all terms as described in it.

Patient Name

Patient Signature

Date