Patient Information

Full Legal Name: _____ **Today's Date:** ____/____/____

Birth Date: _____/_____/_____ **Sex:** ❑M ❑F **Marital Status:** Married Single Other

Street Address _____ **P.O. Box**_____

City _____ **State** _____ **ZIP code** _____ **Email:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

How do you prefer appointment reminders? ❑Text ❑Voice

Race (circle): Black or African Am. Native Hawaiian, Pacific Islander American Indian, Alaska White Asian Other

Ethnicity (circle one): Hispanic Non-Hispanic **Smoking (circle one):** Everyday Some days Former Never

Occupation: _____ **Employer:** _____

How did you hear about us? ❑Web search ❑Phone book ❑Newspaper ❑Insurance ❑Friend/family_____ ❑Dr._____ Other_____

Primary Care Physician _____

Preferred Pharmacy _____ **Pharmacy Location** _____

Insurance Information

Primary Insurance: _____ Policy #: _____ Co-Pay: _____

Policy Holder Employer: _____ Group #: _____

Subscriber's Name: _____ SSN: _____ Birth Date: _____

Patient's Relationship to Subscriber: ❑Self ❑Spouse ❑Child ❑Other Is this person a patient here? ❑Yes ❑No

Person Responsible for Bill: _____ Birth Date: _____

Address (if different): _____

Name of Secondary Insurance (if applicable): _____

Subscriber: _____ Patient's Relationship to Subscriber: ❑Self ❑Spouse ❑Child ❑Other

Group #: _____ Policy #: _____

In Case of Emergency

Name: _____ Relationship to Patient: _____

Home Phone Number: _____ Work Phone Number: _____

The above information is true and correct to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Ginn Foot and Ankle or insurance company to release any information required to process my claims.

Acknowledgment of receipt of Privacy Practices (HIPAA)

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Signature (or guardian signature if under 18) **Date**

PATIENT FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you. Your complete understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.

I PLAN TO MAKE PAYMENT OF MY MEDCIAL EXPENSES AS FOLLOWS: _____ CASH _____CHECK _____CREDIT CARD

As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. We will also keep track of necessary documentation, referrals, and pre-certifications you will need to be treated at our office. However, as our patient, you are ultimately responsible for all authorizations/referrals needed to seek treatment in this office. You must inform the office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied. Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. If you are undergoing a surgical procedure, Insurance out of pocket for surgery fees are required prior to surgery. If not covered by insurance, payment is expected in full. It is expected that all fees be paid in full within 90 days of the date of surgery whether you insurance payment has been received or not. Pre-certification of surgical procedures will be done as a courtesy to you; however, it is ultimately your responsibility to notify your insurance carrier prior to any surgical procedure.

Your insurance policy is a contract between you and your insurance company. If your insurance company does not pay the practice within a 90 day period following an office visit, you will be responsible for any unpaid balance. We have made prior arrangements with most insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service. "Usual and customary" rates may be different from charges for services rendered. You will be responsible for payment of any differences without regard to insurance determination of usual and customary or similar type coverage by insurance carrier(s). In addition, you agree not to delay on payment due to personal bankruptcy and or attorney advisement to not pay on the account nor any court action including and not limited to worker's compensation cases or injuries.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you are mainly responsible for charges of any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

If you are Medicare eligible, a claim will be filed on your behalf for covered services. We will file claims for non-covered services upon request.

The responsibility for payment of services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office.

Any credit balances on a patient's account will be applied to any unpaid balances. Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office. There is a service fee of $30.00 for all returned checks. Your insurance company does not cover this fee. A fee may be charged if you fail to cancel your appointment within 24 hours and/or do not show for your appointed time. In addition, all unpaid balances 91 days past due will incur interest of 1.5% per month which will be applied from day 31 from the date of service until the balance is paid in full. All payments are due by the tenth (10^{th}) day of each month. Thank you for you understanding or our Financial Policy.

I authorize treatment of the person named below and agree to pay all fees and charges for me and my family shown by statements promptly upon presentation thereof unless credit arrangements are agreed in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. I fully understand all terms and conditions, and this has been fully explained to my / our satisfaction, and I/we have completely read this financial agreement and authorization for treatment.

AUTHORIZATION AND ASSIGNMENT

I authorize Ginn Foot and Ankle to release medical information that may be necessary to request claim reimbursement from insurance companies to process my claim(s). I also authorize claim payments including major medical benefits to be made to Ginn Foot and Ankle. I understand that I will be refunded any overpayment. I understand that I am ultimately responsible for payment of my account and if this assignment or claim is rejected, it will be my responsibility to pay any unpaid charges in full.

I authorize Ginn Foot and Ankle to secure whatever information regarding any claim to any insurance company doctor he feels necessary in assisting me in reaching its settlement or understanding of certain aspects of its settlement. This authorization and assignment may be revoked by me at any time by a written notice.

I agree a photocopy of this for may be used in lieu of the original.

_____ Date: ____/____/____

Signature of Patient/Responsible Party:

Printed Name: _____

_____ Date: ____/____/____

Witness:

Printed Name: _____

Ginn Foot and Ankle

PATIENT MEDICAL HISTORY FORM

Patient Name:_____DOB:____/____/_____

Gender: M F Height: _____ Weight: _____ Current Shoe Size: _____

What is the main problem with your feet and ankles today? :

_____

_____

Please describe the nature of the problem (burning, achy, sharp). : _____

Please describe the exact problem area. : _____

When did you first notice this? : _____

How did this start? :_____

Is this constant or

occasional? :_____

What makes this worse? : _____

What have you tried up to today? : _____

ALLERGIES: (additional space is at the end of the form)

_____ I have no known drug allergies.

_____ I am allergic to the following medications:

_____

_____

MEDICATIONS - Including vitamins & over-the-counter meds with dosing**:** (additional space is at the end of the form)

_____ _____ _____ _____

_____ _____ _____ _____

MEDICAL HISTORY:

Do you have or have you ever had/been diagnosed with any of the following medical conditions?

◊ Diabetes (circle type): Type I Type II How often do you check your blood sugar? _____ What is your average daily reading? _____

◊ High Blood Pressure	◊ Osteoarthritis (DJD)	◊ Kidney Disease	◊ Psoriasis	◊ Cancer_____
◊ High Cholesterol	◊ Rheumatoid Arthritis	◊ Hypothyroid (low)	◊ Eczema	◊ Parkinsons Disease
◊ Heart Failure	◊ Gout/Gouty Arthritis	◊ Hyperthyroid (high)	◊ Basal Cell Carcinoma	◊ MS
◊ Heart Attack	◊ Psoriatic Arthritis	◊ Liver Disease	◊ Sqamous Cell Carcinoma	◊ ADD/ADHD
◊ Heart Murmur	◊ Fibromyalgia	◊ Hepatitis A, B, or C	◊ Melanoma	◊ Shingles
◊ Stroke	◊ Polio/Post-polio	◊ Tuberculosis (TB)	◊ Warts	◊ Other _____
◊ Varicose Veins	◊ Raynaud's Disease	◊ Asthma	◊ Cataracts	_____
◊ Clotting Disorder	◊ Gastric Reflux (GERD)	◊ Emphysema	◊ Hearing loss/hearing aids	_____
◊ Anemia or Sickle Cell	◊ Stomach Ulcer	◊ COPD	◊ Rheumatic Fever	
◊ Edema or Lymphedema	◊ Diverticulitis	◊ Epilepsy	◊ HIV or AIDS	
◊ Peripheral Vascular Disease	◊ Hernia	◊ Depression or Anxiety	◊ RSD	

SURGERIES:

Please list all surgeries you have had –use an additional sheet if more space is needed.

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

****Please don't forget to fill out the other side.****

SOCIAL HISTORY:

Tobacco: ◊ No ◊ Yes How much & what kind? _____

Alcohol: ◊ No ◊ Yes How much & what kind? _____

Illicit Drugs: ◊ No ◊ Yes How much & what kind? _____

Exercise Routine: ◊ No ◊ Yes How often & type of exercise? _____

Regular Sports Activity: ◊ No ◊ Yes How often & type of activity? _____

FAMILY HISTORY:

◊ Diabetes Who? _____ ◊ High Blood Pressure Who? _____

◊ Heart Disease Who? _____ ◊ Stroke Who? _____

◊ Cancer Who? _____ ◊ Gout Who? _____

REVIEW OF SYMPTOMS:

Do you experience any of the following unusual symptoms on a regular basis?

◊ Severe Headaches
◊ Dizziness
◊ Rapid Weight Loss/Gain
◊ Unusual Fatigue
◊ Blurred Vision
◊ Excess Eye Watering
◊ Excessive Dry Eye
◊ Ringing in the ear(s)
◊ Difficult Swallowing
◊ Bleeding Gums
◊ Fast/Racing Heart Beat
◊ Chest Pain or Tightness
◊ Leg/Foot Swelling
◊ Shortness of Breath
◊ Wheezing
◊ Constipation
◊ Watery Stools
◊ Abdominal Pain
◊ Muscle Weakness
◊ Leg Cramps
◊ Joint Swelling
◊ Skin Rash or Hives
◊ Dry, Scaly Skin
◊ Tingling Pains
◊ Burning Pains
◊ Tremors
◊ Depression
◊ Anxiety
◊ Mental Status Changes
◊ Unusually Dry Skin
◊ Excessive Thirst
◊ Unusual/Unexplained Bruising
◊ Unusual Nose Bleeds
◊ Hay Fever

OTHER:

Do you wear prescription glasses or contacts?	◊ Yes	◊ No
Do you have a pacemaker?	◊ Yes	◊ No
Are you on dialysis?	◊ Yes	◊ No
Are you pregnant?	◊ Yes	◊ No
Are you nursing?	◊ Yes	◊ No

Which pharmacy do you prefer?_____

Who is your primary care physician?_____

Additional Information:

I do freely give my permission to Dr. Ginn to diagnose and administer treatment for my foot and ankle condition and authorize any release of information obtained in the course of my treatment.

Patient/Guardian Signature: _____ Date: _____