

HILLSIDE
Foot & Ankle
ASSOCIATES LLC

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

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 understand the Notice.
You may refuse to sign this form if you wish.

Patient Name (please print)

Authorized Representative, if applicable (please print) Relationship

Signature

Date



HILLSIDE
Foot & Ankle
ASSOCIATES LLC
PATIENT INFORMATION FORM (PLEASE PRINT)

Date: ___/___/___ Social Security #: _____

Patient Name: _____ Date of Birth: ___/___/___ Sex: M F
Last First MI

Home Address: _____ City/State: _____ Zip: _____

Home Phone: (____) _____ - _____ Yes No May we leave a message?

Cell Phone: (____) _____ - _____ Yes No May we leave a message?

Email: _____

If you would like us to release medical information to family members or other individuals, please list their name and relationship: _____

Primary Language: _____ Ethnicity: ___ Not Specified ___ Hispanic/Latino ___ Not Hispanic / Latino
Race: ___ White ___ Amer. Indian/Alaska Native ___ Asian ___ Black/African Amer. ___ Native Hawaiian/Pacific Is.
___ Not Specified

Emergency Contact: _____ Relationship: _____ Phone #: (____) _____ - _____

Primary Care Doctor: _____ Date last seen: _____ Pharmacy: _____

Who is responsible for payment? _____ Relationship to patient? _____

Address: _____ City/State: _____ Zip: _____

Phone #: (____) _____ - _____ Birthdate: _____ Social Security # _____

Do you have a legal guardian or healthcare power of attorney? Yes No

If yes, Name: _____ Relationship: _____ Phone #: (____) _____ - _____

Whom may we thank for referring you to us? _____

Insurance Information

Primary Insurance Company Name: _____

Policy #: _____ Group #: _____

Subscriber: _____ Subscribers Birthdate: _____ SS#: _____

Secondary Insurance Company Name: _____

Policy #: _____ Group #: _____

Subscriber: _____ Subscribers Birthdate: _____ SS#: _____

Social History

Marital Status: Single Married Partnered Separated Divorced Widowed

Use of Alcohol: Never No longer use History of alcohol abuse

Current Use - Type _____ Rare Occasional Moderate Daily

Use of Tobacco: Never Quit - how long ago? _____ Smoke _____ packs/day for _____ yrs

Use of Recreational Drugs: Never Quit - How long ago? _____ Type _____

Current Use - Type _____ Rare Occasional Moderate Daily

Employer: _____ Occupation: _____ Phone #: (____) _____ - _____

How much are you on your feet at work? 10% 25% 50% 75% 100%

OVER 

Family History Please indicate, using the following letters: F(Father), M(Mother), B(Brother), S(Sister), D(Daughter), C(Son) who in your family has a history of:

Diabetes _____ Cancer _____ Heart Disease _____ High Blood Pressure _____
 Stroke _____ Coronary Artery Disease _____ Thyroid Disease _____
 Rheumatoid Arthritis _____ Other _____

Your Medical History

Height: _____ Weight: _____ Shoe Size: _____
 Allergies: None Known Penicillin Medications Anesthesia Other _____
 Foods Tape Latex Shellfish Iodine Anesthesia Other _____

Place a check mark in the box to indicate if you have ever had any of the following?
 Yes No

Other Conditions:		Yes	No
Acid Reflux			
Anemia			
Arthritis			
Asthma			
Back Trouble			
Bladder Infections			
Abnormal Bleeding			
Blood Clots			
Blood Transfusion			
Bronchitis/Emphysema			
Cancer			
Diabetes			
Fibromyalgia			
Gout			
Heart Attack			
Heart Disease/Failure			
Hepatitis			
HIV/AIDS			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Liver Disease			
Low Blood Pressure			
Migraine Headaches			
Mitral Valve Prolapse			
Neuropathy			
Open Sores			
Pneumonia			
Polio			
Rheumatic Fever			
Skin Disorder			
Sleep Apnea			
Stomach Ulcers			
Stroke			
Thyroid Disease			
Tuberculosis			

List all medications and dosages you are currently taking (Include prescriptions, over-the-counter meds and herbal supplements):

List all prior surgeries:
 Date Type of Surgery

Date Type of Surgery

Date Type of Surgery

List all prior hospitalizations (other than for surgery) in the last 12 months:
 Date Reason

Date Reason

Date Reason

Current Problem

What specific problem brings you to our office today? _____

Where is the pain/problem located? _____

How long ago did this problem first start? _____ Days / Weeks / Months / Years

Did your pain or problem: Begin all of a sudden Gradually develop over time

How would you describe your pain? No pain Sharp Dull Aching Burning
 Radiating Itching Stabbing Other _____

How would you rate your pain on a scale from 0 to 10? (please circle)
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

Since the time your pain or problem began, has it: stayed the same become worse
 Improved

What makes your pain or problem feel worse? Walking Standing Daily activities
 Resting Dress shoes High heels Flat shoes Any closed toe shoe
 Running Other _____

What makes your pain or problem feel better? _____

What treatments have you had for this problem? _____

How has this problem affected your lifestyle or ability to work? _____

Was this problem caused by an injury? Yes (describe) _____ No
If yes, was it a work-related injury? Yes No

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Print name of Patient, Parent or Guardian

Signature

Date

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with the above noted insurance and assign directly to Hanover Foot & Ankle associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Hanover Foot & Ankle Associates to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Date



HILLSIDE
Foot & Ankle
ASSOCIATES, LLC

Patient Financial Policy

Your 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 office manager.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- 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. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. 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. If your insurance company does not pay the practice within a reasonable period, you may be responsible for payment.
- We have made prior arrangements with certain 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.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- 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 or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- 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.
- Missed appointments are disruptive to our office and deprive others from an appointment to see the doctor. Twenty-four (24) hour cancellation notification is required to avoid a \$35 no-show fee per appointment slot.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of \$25.00 for all returned checks. Your insurance company does not cover this fee.

I the undersigned certify that I (or my dependent) have insurance coverage with the insurance information I have provided and assign directly to Hillside Foot and Ankle Associates, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Hillside Foot and Ankle Associates, LLC to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions,

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____

Date: _____

