Idaho Foot & Ankle Center

1540 ELK CREEK DRIVE, IDAHO FALLS ID 83404 • 393 EAST 2ND NORTH, REXBURG ID 83440

Name: _____ Date of Birth: _____

Permanent Billing Address: _____

City: _____ State: _____ Zip Code: _____

Marital Status: _____ Gender: (M / F) Primary Language: _____

Race: _____ Social Security #: _____ Employer: _____

If Patient is a Minor Child Name of Guarantor: _____ DOB: _____

Primary Care Physician: _____ Preferred Pharmacy: _____

How did you hear about us? _____

Preferred Phone #: _____ Would you like to receive text message reminders? (Y / N)

Secondary Phone #: _____ Email: _____

Emergency Contact: _____ Phone #: _____

Permission to Discuss Your Medical Information: *(Example: Spouse, Caretaker, Other Physician…. etc.)*

1. Name: _____ Relationship: _____
2. Name: _____ Relationship: _____

PLEASE PROVIDE US A COPY OF YOUR INSURNACE CARDS

Primary Insurance: _____ Member ID: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder Date of Birth: _____ Policy Holder SS #: _____

Secondary Insurance: _____ Member ID: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder Date of Birth: _____ Policy Holder SS #: _____

PATIENT CONSENT & OBLIGATION: I ACKNOWLEDGE RECEIPT OF **THE NOTICE OF PRIVACY PRACTICES** AND ACCEPT AND UNDERSTAND ITS TERMS. I AUTHORIZE AND REQUEST PHYSICIAN AND STAFF TO PROVIDE ME WITH ANY AND ALL NECESSARY EVALUATIONS AND/OR TREATMENT. I AUTHORIZE THE RELEASE OF/REQUEST FOR NECESSARY INFORMATION TO/FROM PHYSICIANS FACILITIES AND OTHER CARE GIVERS THAT WILL AID IN MY DIAGNOSIS AND CARE, INCLUDING THE REVIEW OF MY PRESCRIPTION HISTORY FROM EXTERNAL SOURCES. I AUTHORIZE THE RELEASE OF/REQUEST FOR NECESSARY INFORMATION TO/FROM MY INSURANCE COMPANY THAT WILL AID IN THE PAYMENT FOR THE SERVICES RENDERED. I AUTHORIZE AND REQUEST PAYMENT FOR SERVICES RENDERED BE MADE DIRECTLY TO PHYSICIAN.
I AGREE TO ABIDE BY THE TERMS OF THE PATIENT **FINANCIAL POLICY/AGREEMENT** AND UNDERSTAND THAT INSURANCE AND FILING DOES NOT RELEASE ME FROM BEING RESPONSIBLE FOR ACCRUED CHARGES AND AGREE TO PAY MY BILL IN FULL WITHIN 60 DAYS OF RECEIVING MY FIRST STATEMENT. I AM AWARE THAT MY ACCOUNT MAY BE TURNED OVER TO A THIRD-PARTY COLLECTION SERVICE INCURRING AN ADDITIONAL 35% FEE AND MAY RESULT IN DAMAGED CREDIT, COURT COSTS, ATTORNEY FEES OR GARNISHED WAGES. PLEASE NOTE THAT DR. KOVAC and DR ERICKSON HAVE FINANCIAL INTEREST IN MADISON AVE SURGERY CENTER. THIS DOES NOT LIMIT YOUR CHOICE TO HAVE SURGERY/PROCEDURE PERFORMED AT ANOTHER FACILITY. PLEASE SEE THE REVERSE SIDE FOR A COPY OF THE COMPLETE FINANCIAL POLICY/AGREEMENT.

_____ _____

Signature **Date**

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FINANCIAL AGREEMENT

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high-quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at time of visit. If you are insured by a plan we participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. We accept Medicare benefit amounts. Medicare as well as your secondary insurance (if any) will be billed on your behalf. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments associated with your plan of coverage. Coinsurance/ Copays will not be collected at assisted living centers.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive will not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for full payment of these services at the time of the service.

REFERRAL/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan. Some insurances mandate that when you visit a specialist office such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of the visit, you will be financially responsible for all services received due in full at completion of the visit. Full credit will be given if referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: **ALL CO-PAYMENTS, CO-INSURANCE, OR DEDUCTIBLE AMOUNTS MUST BE PAID AT THE TIME OF SERVICE.** This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductible from patients can be considered fraud. Please help us in upholding the law by paying your portion of insurance benefits at each visit. As a courtesy, our office does verify benefits of your insurance carrier; however, the insurance agreement is a contract between you and your insurance carrier. It is recommended that you verify your benefits with your carrier as well.

NON-CUSTOM DURABLE MEDICAL EQUIPMENT RETURNS: If a patient is unsatisfied with any non-custom Durable Medical Equipment item, it must be returned within 30 days per Medicare guidelines. Returns after 30 days will not be permitted. The item will only be accepted as a return if it is in returnable condition. Any custom durable medical equipment item may not be returned for any reason.

COPY FEE: We will provide copies of patient records at the patient's request. Copies of records may be subject to $0.05 per single page copy fee. You will bear complete financial responsibility for any fee(s) incurred.

COLLECTIONS FEE: You will be sent three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After a third and last notice, your account will be forwarded to our collection agency. If your account is sent to a collection's agency, a **35% FEE** will be added to your account. You bear complete financial responsibility for any fee(s) incurred. Payment arrangements can be made on a case-by-case basis. We accept the following payment methods: Cash, Check, Visa/Mastercard/Discover/American Express. An additional $25.00 will be added to your statement if your check is returned from your bank. In the event that your insurance company sends payment to you, the patient, it should be forwarded to our office to be applied to your balance.

ASSIGNMENT OF BENEFITS: I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **IDAHO FOOT & ANKLE CENTER** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services, and other fees **AT THE TIME OF SERVICE**: I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize Release of Medical Information to my insurance carrier or requested physician to provide continuity of care. I authorize the use of signature on all insurance submissions.

PATIENT NAME: _____

CURRENT PODIATRIC PROBLEMS:

What is the specific complaint today? _____

How long has it been a problem? _____

What have you done to treat the problem so far?

_____

_____

Have you ever been cared for by a Podiatrist before? [ ] N [ ] Y When/Who:_____

Height: _____ Weight: _____ Shoe Size: _____

PAST MEDICAL HISTORY: (Please mark all that apply)

□AIDS/HIV
□Alcoholism
□Acute Urinary Tract Infections
□Anemia
□Anxiety
□Arthritis
□Asthma
□Atrial Fibrillation
□Bronchitis/Pneumonia
□ Cardiac Pacemaker
□ Cellulitis
□Cerebral Palsy
□COPD/Pulmonary Disease
□Clotting/Bleeding Disorders
□DVT/Blood Clots
□Depressive disorder
□Diabetes (Type I-Type II –Prediabetes)
□Downs Syndrome
□Epilepsy
□Fibromyalgia
□Fractures: Location_____
□GERD/Stomach Ulcers
□Gout
□Heart Attack: Year_____
□Heart Problems/ Coronary Artery Disease
□Hepatitis A/B/C
□High Cholesterol
□High Blood Pressure
□Immune Disorder
□Irritable Bowel Disease/Crohn's Disease
□Kidney Disease
□Leg/Foot Ulcer
□Liver Disease/Problems
□Low Blood Pressure
□Lupus
□MRSA-Infection
□Neurostimulator
□Multiple Sclerosis
□Peripheral Neuropathy
□Plantar Fasciitis/Heel Pain
□Poor Circulation/ Peripheral Arterial Disease
□Psoriasis
□Psychiatric Illness
□Raynoud's Disease
□Rheumatoid Arthritis
□Sleep Apnea
□Spine Injury/Deformity
□Stroke
□Swelling in foot/ankles
□Tendinitis
□Thyroid Disease
□Toenail Problems
□ Other: _____

PAST SURGICAL HISTORY:

YEAR	SURGERY/PROCEDURE	YEAR	SURGERY/PROCEDURE

CURRENT MEDICATIONS:

MEDICATION	DOSAGE	MEDICATION	DOSAGE

ALLERGIES:

ALLERGY	REACTION

PATIENT NAME: _____

SOCIAL HISTORY:

	Y	N	AMOUNT	HOW OFTEN
Caffeine (Coffee/Soda)	□	□		
Tobacco (Former or Current)	□	□		
Alcohol (Former or Current)	□	□		
Drugs, Recreational	□	□		
Exercise	□	□		

FAMILY HISTORY:

DO YOUR PARENTS HAVE A HISTORY OF (PLEASE MARK)	RELATIONSHIP TO YOU
□Arthritis	[ ] Mother [ ] Father
□Bleeding Disorder	[ ] Mother [ ] Father
□Cancer	[ ] Mother [ ] Father
□Circulation Problems	[ ] Mother [ ] Father
□Diabetes	[ ] Mother [ ] Father
□Heart Disease	[ ] Mother [ ] Father
□Neurological	[ ] Mother [ ] Father
□Stroke	[ ] Mother [ ] Father

Review of Symptoms: Please **CIRCLE** any of the **SYMPTOMS** that you have had within the last 30 days and are **NEW** to you

Cardiovascular:	**Ear, Nose, Mouth, Throat:**	**Genitourinary:**	**Neurological:**
chest pain	loss of hearing	difficult/painful urination	burning sensation
palpations	loss of smell	blood in urine	paralysis
fainting	dry mouth	frequent urination	seizures
heart murmurs	difficulty swallowing	leaking urine	numbness
leg cramps	dentures		tingling
	nose bleeds	**Integumentary:**	tremors
Constitutional:	ringing in ears	skin ulcers	
pregnant		poor healing wounds	**Psychiatric:**
dizziness	**Eyes:**	toenail problems	depression
headaches	eye pain	painful callus	dementia
fatigue	cataracts	athletes' foot	memory loss
weight loss	glaucoma	itching	anxiety
fever	dry eyes	rash	
chills	blindness	scarring/keloids	**Respiratory:**
weight gain	glasses/contacts		wheezing
		Musculoskeletal:	difficult breathing
Endocrine:	**Gastrointestinal:**	muscle cramps/aches	persistent cough
decreased appetite	heartburn	knee pain	shortness of breath
excessive thirst or urination	nausea/vomiting	joint pain	
sensitive to cold or heat	constipation	joint swelling	
	diarrhea	joint stiffness	
	bloody/tarry stools	unsteady gait	
		foot pain	
		toe pain	
		ankle pain	

I have reviewed and answered the new patient forms to the best of my knowledge.

Signature of Patient or Parent/Legal Guardian	Relationship to Patient	Date

Medication Management Policy

Idaho Foot & Ankle Center is dedicated to promoting excellent foot and ankle care for the whole family with a conservative and friendly approach. Prescriptions are only given to patients under active treatment with Idaho Foot & Ankle Center providers. It is important to take the medications as prescribed. All medications must be kept in a safe place and used solely for the intent in which they were prescribed by the doctor. In an effort to help control the increasing rate of addiction and abuse to Narcotic medication (known also as the "Opioid Epidemic), narcotic pain medications will only be prescribed by doctors for patients in either a Post-Surgical situation, or in an acute injury setting, and only for a limited amount of time, not to exceed 6 weeks.

Post-Surgical Narcotic Pain Management

We understand that Pain control following surgery is a priority for our patients and our doctors. While you should expect to have some amount of pain following surgical procedures, our doctors will make every effort to safely lessen the pain. Narcotic prescriptions may be prescribed as needed to patients undergoing surgery by Idaho Foot & Ankle Center Physicians. Narcotics will only be prescribed as deemed necessary by the operating physician and for the length of time needed for proper control of pain, not to exceed 6 weeks following the date of surgery. If pain control is still needed following the 6-week post-surgery visit, other methods of pain control will be discussed between the doctor and patient. Possible alternatives may include but not be limited to the following list. For example, use of non-narcotic pain medications, pain creams, use of MLS pain laser therapy, referral to Physical Therapy or transferring care to a pain management specialist**.**

I am on a pain contract with a physician. Yes ____ (Dr. _____) No ____

Maintenance Medications

Patients of the Idaho Foot and Ankle Center that are taking maintenance/long term medications must schedule an appointment at least every 6 months to keep their maintenance medication prescription current. No prescription refill requests will be granted to patient's that have not visited in the office with the doctor within a 6-month period.

Refill Requests

Idaho Foot and Ankle Center and their staff will do their best to address prescription refills in a timely manner. We will make every effort to authorize prescription refills as soon as possible however, please allow at least 48 hours for these refills to be processed. Remember to plan ahead so there is not a lapse in your medication therapy.

I give consent to import medication history from my pharmacy for the purpose of providing direct health care services.

_____ _____

(Name of Patient) (Signature of Signer)

_____ _____

(Relationship to Patient) (Date)