Patient Demographic Form

Patient Name: _____ **Date of Birth:** _____
First M Last

Social Security #: _____ **Gender**: Male Female **Marital Status**: S/M/W/D

Race: _____ **Ethnicity:** Hispanic/Latino or Non-Hispanic/Latino **Language:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Email:** _____

Home Phone #: _____ **Cell #:** _____

Employer: _____ **Work #:** _____

Spouse

Name: _____ **Date of Birth:** _____

Social Security #: _____ **Spouse phone #:** _____

Employer: _____ **Work #:** _____

If the patient is a Minor/Student

Mother's Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Email:** _____

Home Phone #: _____ **Cell #:** _____

Father's Name: _____ **Date of Birth:**_____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Email:** _____

Home Phone #: _____ **Cell #:** _____

Emergency

Name/Relationship Phone Allowed to talk about:

_____ Medical Financial

_____ Medical Financial

_____ Medical Financial

Insurance Information

Primary

Insurance Co: _____ Policy Holder/Relationship _____

Policy Holder's DOB _____ Policy Holder's SSN _____

Secondary

Insurance Co: _____ Policy Holder/Relationship _____

Policy Holder's DOB _____ Policy Holder's SSN _____

Financial Agreement

I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed to ensure that payment for services rendered is received. I understand that I am ultimately responsible for payment of all services. I will pay any unpaid balance by cash, check or credit card (VISA/MASTERCARD/DISCOVER). For accounts to stay in good standing, payment must be made **every 30 days**. Every effort will be made to work with our patients on delinquent accounts, but if the account is in default, it will be turned over to a collection company where you could be responsible for collection effort fees, including interest, attorney fees and court costs.

_____ _____ _____

Print name of Patient/Parent/Guardian Signature of Patient/Parent/Guardian Date

Insurance Authorizations

I hereby authorize any insurance company to pay the proceeds of any assigned benefits directly to Mark H. Runkle, DPM or Dr Jeffrey S. Stevens, DPM. I authorize Dr. Mark H. Runkle, DPM or Dr Jeffrey S. Stevens, DPM to release any medical information necessary to process insurance claims on my behalf. A copy of this can be considered as an original for insurance purposes.

Signed _____ Date _____

I understand I am responsible for meeting the requirements of my insurance policy. I understand any charges not paid by my insurance are my responsibility and I will be responsible for any collection or legal fees necessary to collect said charges.

Signed _____ Date _____

PATIENT HISTORY

Please fill out **FRONT AND BACK portions of **ALL FORMS** to the best of your ability. The staff will go over the form and answer any questions you may have.**

Name: _____ Date: ___ /___ /_____

E-mail address: _____ DOB: ___ /___ / _____

May we contact you via e-mail _____YES _____NO

Age: _____ Height: _____ Weight: _____ Shoe Size: _____

Were you referred to our office? YES NO If yes, by whom? _____

If you were not referred by someone, how did you find out about our office? _____
_____

1. What is the main problem with your feet and/or ankles? _____
_____
_____

2. When did you first notice this condition? _____
3. Is the condition due to an injury? ____YES ____NO If yes, when did it occur? ____ / ____ / _____
If yes, did the injury happen at work? ____YES ____NO
Are you claiming Workman's Comp? ____YES ____NO

4. Check all of the following that apply:
Type of Pain ___Burning ___Tingling ___Sharp ___Dull Ache ___Shooting ___Stabbing ___Numbness

Pain ___Upon Standing ___During Walking ___After Walking
___During Sports ___A.M. ___P.M. ___Always ___While Lying in Bed
___Worse When Standing ___Worse With Activity ___Better As Activity Continues
___Worse Wearing Shoes ___Worse Without Shoes

5. How painful is your condition? 0 = NO PAIN and 10 = WORST PAIN EVER EXPERIENCED

Please circle your pain level: 0 1 2 3 4 5 6 7 8 9 10

6. How has this condition affected your daily routine and what activities does this keep you from performing?
_____
_____

7. Have you had foot care before? ___YES ___NO If yes, by whom and when: _____
_____

MEDICATIONS

PHARMACY: _____ Location: _____ Phone:_____

Note: If you have a list of medications that we are able to make a copy of, you do not need to fill out this part of the form.

**MEDICATION	DOSAGE	HOW OFTEN TAKEN?	WHAT IS IT TAKEN FOR?**

****Need this information, please.**

ALLERGIES

□ NONE □ OTHER _____

□ Penicillin □ Sulfa □ Iodine □ Aspirin □ Anesthetics □ Latex

□ Codeine □ Demerol □ Darvocet □ Cortisone □ Environmental □ Food

TYPE OF REACTION: _____

MEDICAL HISTORY

Primary Care Physician (PCP): _____

Date of Last Physical Exam: ___ / ___ / _____

Please check any of the following **conditions** that you **currently** have:

□ Diabetes □ Thyroid Disease □ Tumors □ Cancer- _____ □ Epilepsy □ Gout

□ Arthritis □ Bursitis □ Asthma □ COPD □ Lung Disease □ Skin Disorders

□ Heart Problems □ High Blood Pressure □ High Cholesterol □ Stroke □ Glaucoma

□ Anemia □ AIDS/HIV □ Sexually Transmitted Disease □ Stomach Ulcers □ Heart Burn

□ Acid Reflux □ Colitis / Crohn's □ Nerve Conditions □ Mental Disorder □ Rheumatic Fever

□ Kidney/Urinary Problems □ Hepatitis □ Sickle Cell □ Tuberculosis □ Osteoporosis

□ Joint Implants _____ □ _____

□ **DIABETES:** WHAT IS THE NAME, PHONE #, AND ADDRESS OF THE DOCTOR TREATING YOU FOR DIABETES?

_____

When was your last visit? __ / __ / ____ What is your average blood sugar reading? _____

List any **conditions** that you had in your **past**, but have resolved: _____

_____

Are you currently pregnant? ___ YES ___ NO If yes, how many months? _____

SURGICAL HISTORY

PROCEDURE	DATE	COMPLICATIONS

HAVE YOU EVER BEEN HOSPITALIZED OTHER THAN FOR SURGERY? ___ YES ___ NO
EXPLAIN: _____

HAVE YOU EVER HAD AN INJURY TO THE LOWER EXTREMITY? ___ YES ___ NO
EXPLAIN: _____

FAMILY HISTORY

PLEASE CHECK ALL THAT APPLY

	FATHER	MOTHER	BROTHER	SISTER
DIABETES				
HEART DISEASE				
HIGH BLOOD PRESSURE				
ARTHRITIS				
GOUT				
THYROID DISEASE				
CANCER (TYPE)				
OTHER				

SOCIAL HISTORY

Occupation: _____

Activities: _____

Level of activity: ___ Occasional ___ Weekly ___Competitive ___ Professional

DO YOU SMOKE TOBACCO? ___ YES ___ NO If yes: # of packs per day ____ # cigarettes per day? _____
# of years smoking? ____

DID YOU EVER SMOKE? ___ YES ___ NO If yes: How long ago did you quit smoking? _____

DO YOU DRINK ALCOHOL? ___ YES ___NO If yes: How much? __< 1/week __1-2/week __1-2/day __more

RECREATIONAL DRUG USE

❿ Any type of drug use is a personal choice and will in no way adversely affect your relationship with the doctor. However, many drugs can interact with other medications and treatments with potential life threatening effects. Therefore, it is extremely important that you answer honestly. Your response will be held in the most strict patient-doctor confidentiality. A**nswer:** ___YES ___NO **If** yes: What substance and how often used? _____

REVIEW OF SYSTEMS (ROS)

If you are experiencing any of the following, please circle.

Head: chronic headaches, concussion, dizziness, loss of consciousness

Eyes: glasses, contacts, double vision, blurred vision, blindness, cataracts

Ears: decrease or loss of hearing, ringing in the ears, chronic earaches

Nose: drainage or infection, blockage, bleeding, sinusitis

Throat: chronic tonsillitis, laryngitis, difficulty swallowing, loss of speech

Cardiovascular: chest pain, shortness of breath, palpitations, murmurs, heart valve disease, anemia, leg cramps

Respiratory: bronchitis, pneumonia, difficulty breathing, wheezing, chronic cough

Gastrointestinal: nausea, vomiting, diarrhea, constipation, weight gain or loss, blood in stool, black stool, excessive gas, loss of appetite

Genitourinary: chronic kidney or bladder infections, problems voiding, pain with urination, dark or bloody urine, discharge from penis or vagina

Gynecologic: irregular or painful periods (menstrual cycles), absence of period if not menopause, vaginal discharge

Other: _____

Do your legs swell? ____YES ____NO

Do you have back problems or have had a back injury? ____ YES ____NO

□ **I AM NOT EXPERIENCING ANY OF THE ABOVE SYMPTOMS.**

NOTICE OF PRIVACY PRACTICES (HIPAA REGULATIONS)

□ I have read or been provided with a document entitled "Notice of Privacy Practices." It is required by governmental regulations that all medical facilities provide you with this notice. Please check the box to acknowledge that you have read (or had the opportunity to read, if you chose) and understand the notice. This is a copy of the notice that is yours to keep. If you do not want the copy, simply return it to the receptionist with your other materials.

CONSENT

I certify that the information above is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures, including therapeutic and diagnostic injections, as may be deemed necessary in the diagnosis and/or treatment of my feet.

SIGNATURE: _____ DATE: __ / __ / ____

FINANCIAL POLICY

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 with each 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 your 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 for you. 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, which are usually 20% of the allowed amount for an item or service.

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 time of service if you do not have health insurance. We accept cash, check, most major credit cards, and CareCredit.

NON-COVERED SERVICES: Please be aware that some of the services you receive may 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 service.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist 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 the visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received, due in full upon completion of the visit. Full credit will be given if a 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 the insurance company. Failure on our part to collect co-payments and deductibles 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 may verify benefits with your insurance carrier, however, the insurance agreement is a contract between you and your insurance carrier. It is recommended that you verify benefits with your carrier as well. ANY PATIENT PORTION GENERATING THREE STATEMENTS MAY BE CHARGED A **$10 REBILLING FEE** PER STATEMENT.

PHYSICIAN PHONE CALLS: Phone calls with our physicians are a billable service, may be billed to your insurance company/companies, and are subject to your insurance benefits. You are responsible for your portion of insurance benefits for phone calls.

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 a $0.05 per single page copy fee. You will bear complete financial responsibility for any fee(s) incurred.

CANCELLED/MISSED APPOINTMENT FEE: If you cannot keep your appointment time, please call our office at least 24 hours prior to your scheduled appointment time. There may be a $25 fee for any appointment cancelled or rescheduled under the 24-hour window. Additionally, there may be a $25 fee if you miss a scheduled appointment and are a "No Show." If you miss three or more appointments, you may be required to pay a $50 deposit to hold any future appointment time slots. If you arrive late for an appointment, we may need to reschedule your appointment. You will bear complete financial responsibility for any fee(s) incurred. Repeated missed or late appointments may result in dismissal from our practice.

COLLECTIONS FEE: You will be sent up to three notices about your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account will be forwarded to our collection agency. If your account is sent to a collection 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 or Visa/MasterCard/Discover. An additional $25.00 will be added to your statement if the check is returned from your bank. We do not accept starter checks. 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.

I have read the above policy regarding my *financial responsibility* to Center Grove Foot & Ankle Associates, P.C. or Indy South Foot and Ankle for medical services provided. I agree to pay Center Grove Foot & Ankle Associates, P.C. or Indy South Foot and Ankle any balance unpaid by my insurance carrier for myself or the below person.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to its terms.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Center Grove Foot & Ankle Associates, P.C. 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 this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms:

PRINT Patient Name: _____ **Signature**: _____

If the patient is under 18, please complete the following for the ***FINANCIALLY RESPONSIBLE PARTY***:

PRINT Name: _____ **Signature**: _____

Relationship to Patient: _____ _ **Date:** _____