ELKHORN
FOOT & ANKLE CLINIC

301 Saddle Drive Suite G Helena, MT 59601 P 406.422.5905 F406.422.5425

PATIENT INFORMATION

Patient (Legal) Name: _____

(Preferred Name): _____ **Previous/Maiden Name(s):** _____

Social Security #: _____ **Birth Date:** _____ **Male:** ☐ **Female:** ☐

Mailing Address: _____

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

Patients Employer: _____ **Work Phone #:** _____

Spouse Name: _____ **Phone:** _____ **Spouse Social Security #:** _____

Spouse Birth Date: _____ **Spouse Employer:** _____ **Spouse Work phone #:** _____

COMPLETE THIS SECTION IF PATIENT IS UNDER THE AGE OF 18 OR A STUDENT

Mother's Name: _____ Father's Name: _____

Mother's Social Security #: _____ Father's Social Security #: _____

Address: _____

Mother's DOB: _____ Employer: _____ Work Phone #: _____

Father's DOB: _____ Employer: _____ Work Phone #: _____

NEAREST RELATIVE/FRIEND NOT LIVING WITH PATIENT

Name: _____ **Relationship:** _____

Address: _____ **Phone #:** _____

ABOUT YOUR INSURANCE – We will need a copy of all insurance cards

Primary Insurance: _____ **Secondary Insurance (if applicable):** _____

If Medicaid, Passport provider: _____

WORKERS COMPENSATION INJURY? ☐ **Yes** ☐ **No** **Date of Injury:** _____

AUTO ACCIDENT? ☐ **Yes** ☐ **No** **Date of Loss:** _____

IF YOU ANSWERED "YES" TO EITHER WORK COMP OR AUTO ACCIDENT PLEASE SEE THE BACK OF THIS FORM FOR OTHER <u>REQUIRED</u> INFORMATION NEEDED TO PROCESS YOUR CLAIM

IMPORTANT INFORMATION (PLEASE READ)

I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician and/or his designated providers.

I authorize the release of any medical information necessary to determine benefits payable for insurance claims for services rendered an agree that all proceeds of insurance are assigned to this office where applicable.

I understand that I am financially responsible for all charges whether or not paid by my insurance.

I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 40% of the balance, including attorney/court costs will be added to the balance of my account.

PATIENT OR GUARDIAN SIGNATURE: _____ **DATE:** _____

PATIENT OR GUARDIAN SIGNATURE: _____ DATE: _____

Financial Agreement & Treatment Consent:

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 each visit. If you are insured by a plan we participate with but do not have an up-todate 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: Down payment of $100 per visit. Remaining will balance will be reflected on statement.

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: 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 this 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. 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 deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion of insurance benefits at each visit. 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 noncustom 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.

CANCELLED/MISSED APPOINTMENT FEE: If you cannot keep your appointment time, please call our office 24 -48 hours prior to the scheduled appointment time. If you miss 3 or more appointments you may be discharged as a patient from our clinic. If you arrive late for an appointment, we may need to reschedule your appointment.

COLLECTIONS FEE: You will be sent up to 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 the third and last notice, your account will be forwarded to our collection agency. Should you default on payment on your account and a collection agency service is required, all costs of collections will be up to 40% of the balance, including attorney/court costs will be added to the balance of your account.

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 $30.00 will be added to your statement if the 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.

I have read the above policy regarding my financial responsibility to Elkhorn Foot and Ankle Clinic for medical services provided. I agree to pay Elkhorn Foot and Ankle Medical Center any balance unpaid by my insurance carrier for myself or the below named person.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other 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 Elkhorn Foot and Ankle Clinic 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:

I herby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Signature: _____ **Date:** _____
Printed Name: _____
Relationship to Patient: _____

Brief Medical History:

Describe your problem and the duration of the symptoms:

_____

_____

Referring Provider: _____

Primary Care Physician: _____

Accident/Injury: ☐Y ☐N **Work Related:** ☐Y ☐ N **Date of Injury:** / /

MEDICATIONS AND SUPPLEMENTS:

Medication	Dose	Times Per Day	Medication	Dose	Times Per Day

(if more room is needed for medications, please list on the back of this page.)

Pharmacy Name: _____ **Pharmacy Phone:** _____

ALLERGIES or REACTIONS to MEDICINES\FOODS\OTHER AGENTS:

Medication or Allergen	Reaction or Side Effect

PERSONAL MEDICAL HISTORY:

	AIDS/HIV			Epilepsy			Neuropathy
	Anemia			Eye Problems			Phlebitis
	Angina			Foot or leg Cramps			Psychiatric Care
	Arthritis			Gout			Pneumonia
	Asthma			Headaches			Radiation Treatment
	Artificial Heart Valve			Hearing Loss			Rash
	Back Problems			Heart Disease			Respiratory Disease
	Bleeding Disorders			Hepatitis A B C			Special Diet
	Cancer			High Blood Pressure			Stroke
	Chemical Dependency			High Cholesterol			Swelling in Ankles or Feet
	Chest Pain			Hypothyroidism			Tired Feet
	Circulatory Problems			Joint Replacement			Tuberculosis
	Depression			Kidney Problems			Ulcers
	Diabetes Recent A1c: Type I___ Type II_____			Liver Disease			Varicose Veins
	Ear Problems			Low Blood Pressure			Venereal Disease

SURGICAL HISTORY:

Date	Surgery or Reason for Hospitalization	Date	Surgery or Reason for Hospitalization

(if more room is needed, please use the back of this page.)

Social History:
Marital Status:
Who do you live with?
How many children?
Employment status:
Occupation:
Smoking Status:
How much do you smoke per day?
Do you drink caffeinated beverages (cola, coffee, or tea)?
Number of beverages per day:
Do you alcohol?
Number of beverages per day:

Family History:			
Arthritis		Mom	Dad
Cancer	Type:		
Diabetes	Type:		
Gout			
Heart Disease			
High Blood Pressure			
Stroke			
Other:			

OTHER:

Please list any other issues the doctor should be aware of.

_____

_____

_____

_____

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPAA), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

- Conduct, Plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practice.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Persons Authorized to access my information:

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

4.

Signature: _____ **Date:** _____

Printed Name: _____

Relationship to the Patient: _____