Welcome to Associated Foot and Ankle Specialists of Ohio!

We are providers of medical and surgical management of foot and ankle disorders, providing comprehensive care for patients of all ages. Our offices are staffed and equipped to treat medical conditions with the most modern and appropriate techniques available. We strive to provide you with the best service possible with the caring you expect from the area's leading physicians in the treatment of the lower extremity.

Please familiarize yourself with our office policies on these registration forms. A copy of the Notice of Privacy Practices can be found as a downloadable form on our website in addition to the registration desk when you arrive for your appointment.

When you come to one of our offices for the first time, please bring the following items with you:

1. Completed and signed registration forms
2. Current insurance card
3. Method of payment for services (cash, check or charge), including copays and deductibles if they apply
4. Parent or guardian if the patient is a minor (under age 18)

We understand that circumstances arise that can make you late or miss your appointment. Please have the courtesy to inform our staff as soon as possible if you are unable to keep your appointment so that we can release your appointment time to another person waiting for an appointment. If you arrive late for your appointment, we reserve the right to reschedule you for another date. Multiple cancellations and/or missed appointments may result in the dismissal from the practice.

We thank you for choosing Associated Foot and Ankle Specialists of Ohio. We hope your experience is a good one, for we take great pride in the work we do for you. The trust you put in our physicians and staff as well as the family and friends you refer to us are our greatest compliment.

Associated Foot and Ankle Specialists of Ohio, Inc

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, certify that I or my dependent has the insurance stated and hereby authorize my insurance company to assign directly to Associated Foot and Ankle Specialists of Ohio and its physicians all medical benefits 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 the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Patient, Parent or Legal Guardian _____ Date _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Associated Foot and Ankle Specialists of Ohio or its physicians for any services furnished me by my physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES CONFIRMATION

Associated Foot and Ankle Specialists of Ohio is compliant with the Health Insurance Portability and Accountability Act (HIPAA). Please sign below to confirm that a copy of the Notice of Privacy Practices regarding your protected health information has been made available to you.

Signature of Patient, Parent or Legal Guardian _____ Date _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I request that all confidential communication to me from the physicians and staff of Associated Foot and Ankle Specialists of Ohio be handled in the following manner:

(Check all that apply)

- ❑ Written communication to my home address
- ❑ Written communication to my billing address
- ❑ Written communication to my work address
- ❑ Written communication to a different address _____
- ❑ Telephone communication to my home number
- ❑ Telephone communication to my cellular number _____
- ❑ Telephone communication to a different number _____
- ❑ Telephone communication, leaving a message with a family member
- ❑ Telephone communication, leaving a message on my answering machine / voice mail
- ❑ Written communication to my email address _____@_____
- ❑ Other _____

Signature of Patient, Parent or Legal Guardian _____ Date _____

PAYMENT POLICY

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know exactly what those guidelines are at each time of service.

We are pleased to be able to provide this service to you, but it is extremely difficult for us to keep track of all the individual requirements of the plans. Each plan has different stipulations regarding how often services may be rendered and where those services may be performed. Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated. We will do our best to obtain pre-certification for you, but it is your responsibility to know your contract. If pre-certification is required, please inform us so we may obtain prior approval for you.

Many managed care plans require written authorization or referral from your primary care physician for each visit. It is your responsibility to obtain this written authorization or referral before each visit or be sure that follow up visits are covered under your primary referral.

Important: It is your responsibility to inform us of any special requirements and/or necessary referrals per your insurance provider. Medical services may be ordered that are not covered. Payment for these charges is your responsibility.

Copayments and deductibles are your responsibility and we will request payment at the time of service. A patient with no insurance should contact our office to arrange a satisfactory payment plan, if one is needed, prior to your visit or you will be billed for the entire balance.

Financial hardship cases are determined on an individual basis and should be directed to your physician's Office Manager.

There is a returned check fee of $40.

Effective 01/01/2018, there will be a $25 fee added to the patient's account for no-shows and cancellations less than 24 hours prior to the scheduled appointment time.

Any questions or concerns regarding your account or insurance should be directed to our billing office.

With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

Your signature below indicates that you have received, read and understand the above policy.

Signature of Patient, Parent or Legal Guardian _____ Date _____

Associated Foot and Ankle Specialists of Ohio, Inc

MEDICAL HISTORY

Patient _____ Date of Birth _____

Circle the reason(s) for which you are seeing the doctor today:

Infection	Ingrown toenail	Nail fungus	Routine nail care	Diabetic foot check
Pain	Injury / Accident	Work Injury	Bunion	Hammertoes
Heel / Arch pain	Plantars wart	Corns / Calluses	Tailors bunion	Second opinion
Neuroma	Arthritis	Gout	Athlete's foot	Skin problem / Rash
Unknown mass	Foot ulcer	Joint pain		

Other _____

Have you seen a podiatrist before? Yes No Have you seen a doctor for the same reason you are here today? Yes No

Circle the medical conditions that you have now or have had in the past:

Low / High blood pressure	Angina	Heart attack	Congestive heart failure
Mitral valve prolapse	Stroke / TIA	Pacemaker	Asthma
Emphysema / COPD	Hepatitis A / B / C	Liver disease	Cancer_____
Stomach ulcer / GERD	Hiatal hernia	Multiple Sclerosis	Epilepsy / Seizure disorder
Diabetes type 1 / type 2	AIDS / HIV	Sexually Transmitted Disease	Arthritis_____
Overweight / Obesity	Digestive disease	Poor circulation	Drug or Alcohol dependency
Anorexia / Bulimia	Glaucoma	Gout	Kidney disease
Hyper- / Hypothyroidism	Psychiatric disorder	Depression	Fibromyalgia
Anemia	Sickle cell disease / trait	Sleep apnea	Currently or possibly pregnant
High cholesterol	Blood clot / DVT / PE	Tuberculosis	Currently breast feeding
Hearing loss	Bleeding abnormalities	Smoker	Vision problems

Others: _____ Skin disorder

Current Medications: (Attach list if needed. Include both prescription and over-the-counter.)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Allergies and Sensitivities:

_____

_____

_____

Past Surgeries:

_____

Complications with anesthesia? Yes No _____

Artificial joints or valves? Yes No _____

Are there any medical conditions that run in your family? (blood relatives only)

Mother's side: Don't know No Yes:_____

Father's side: Don't know No Yes:_____

Children: Don't have any No Yes:_____

Associated Foot and Ankle Specialists of Ohio, Inc

PATIENT INFORMATION

LEGAL NAME _____
FIRST MIDDLE LAST

ADDRESS _____

CITY, STATE _____ ZIP _____

HOME PHONE (_____) _____

CELL PHONE (_____) _____

OTHER PHONE (_____) _____

DATE OF BIRTH _____ SEX: ☐ MALE ☐ FEMALE

SOCIAL SECURITY # _____

MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

EMPLOYER _____

ADDRESS _____

WORK PHONE (_____) _____

EMERGENCY CONTACT

NAME _____

RELATIONSHIP TO PATIENT _____

PHONE (_____) _____

FAMILY DOCTOR / PRIMARY CARE PHYSICIAN

NAME _____

CITY _____

PHONE (_____) _____

REFERRAL SOURCE

☐ FAMILY / FRIEND ☐ YELLOW PAGES

☐ AFAS WEBSITE ☐ INTERNET SEARCH

☐ INSURANCE LIST ☐ PREVIOUS PATIENT

☐ FAMILY DOCTOR / PCP ☐ ER / URGENT CARE

☐ OTHER DOCTOR: _____

☐ OTHER: _____

PHARMACY

NAME _____

ADDRESS _____

PHONE _____

I CERTIFY THE INFORMATION I HAVE GIVEN
IS TRUE AND CORRECT.

_____ _____

SIGNATURE DATE

RESPONSIBLE PERSON INFORMATION

LEGAL NAME _____
FIRST MIDDLE LAST

ADDRESS _____

CITY, STATE _____ ZIP _____

HOME PHONE (_____) _____

DATE OF BIRTH _____ SEX: ☐ MALE ☐ FEMALE

SOCIAL SECURITY # _____

RELATIONSHIP TO PATIENT _____

EMPLOYER _____

ADDRESS _____

WORK PHONE (_____) _____

INSURANCE INFORMATION

1ST INSURANCE:

COMPANY NAME _____

POLICY HOLDER: ☐ SELF ☐ RESPONSIBLE PERSON (ABOVE)
☐ OTHER (COMPLETE INFORMATION BELOW)

POLICY HOLDER'S NAME _____

POLICY HOLDER'S DATE OF BIRTH _____

POLICY HOLDER'S SOCIAL SECURITY # _____

RELATIONSHIP TO PATIENT _____

POLICY HOLDER'S EMPLOYER _____

2ND INSURANCE:

COMPANY NAME _____

POLICY HOLDER: ☐ SELF ☐ RESPONSIBLE PERSON (ABOVE)
☐ OTHER (COMPLETE INFORMATION BELOW)

POLICY HOLDER'S NAME _____

POLICY HOLDER'S DATE OF BIRTH _____

POLICY HOLDER'S SOCIAL SECURITY # _____

RELATIONSHIP TO PATIENT _____

POLICY HOLDER'S EMPLOYER _____