

# ADVANTAGE FOOT & ANKLE CENTER

## PATIENT REGISTRATION

### PATIENT INFORMATION

Patient's Last Name	First	Middle	<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Dr.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid
			<input type="checkbox"/> Miss	<input type="checkbox"/> Ms.		
Street Address			Birth Date (mm/dd/yyyy)		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Spouse's Name
City	State	Zip Code	Social Security #			Home Phone # ( )
Race: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Other:			Ethnicity: <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino			Cell Phone # ( )
Email			Employer			Employer/Work Phone # ( )
Primary Care Physician (PCP)		PCP's Phone #	Date PCP Last Seen		Referred by:	

### PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN ABOVE)

Name of Person Responsible for Bill	Birth Date (mm/dd/yyyy)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Street Address		Social Security #	
City	State	Zip Code	Email
Employer		Employer Address	
		Home Phone # ( )	
		Cell Phone # ( ) AT&T, T-Mobile, Verizon or Other: _____	
		Employer/Work Phone # ( )	

### INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND PHOTO ID TO RECEPTIONIST)

Primary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)	Relationship to Patient
Member ID#			Specialist Copay \$
Secondary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)	Relationship to Patient
Member ID#			Specialist Copay \$

### IN CASE OF EMERGENCY

Name of Nearest Friend or Relative	Relationship to Patient	Home Phone # ( )	Work or Cell Phone # ( )
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### PHARMACY

Name and Address

Phone #

### MONTHLY STATEMENTS

\_\_\_ Paper \_\_\_ Email

The above information is true to the best of my knowledge. I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Advantage Foot and Ankle Center all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. Advantage Foot and Ankle Center may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X \_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE (Must be 18 or older to sign)

\_\_\_\_\_  
DATE

## ADVANTAGE FOOT & ANKLE CENTER FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

1. It is your responsibility to provide accurate insurance information and to present your insurance ID card and Photo ID (required by Federal Law) at the time of your visit. If you do not present a valid insurance card or photo ID, you will be rescheduled.
2. **COPAYMENTS** are due at the time of visit. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurances and deductibles from patients can be considered a violation of the contract you have with your insurance company.
3. **REFERRALS:** If your plan requires a referral, it is your responsibility to obtain this from your PCP prior to being seen by our provider. If you do not have a valid referral, you will be rescheduled. (Referrals are done electronically, PCP must contact insurance company).
4. **SELF PAY PATIENTS:** Payment in full is due at the time of service.
5. As a courtesy, we will be happy to bill your primary and secondary insurance company on your behalf. It is up to each patient to know the rules and limitations of your policies.
6. You are responsible for any portion not covered by your insurance, such as deductible, co-insurance and/or copay. Please read your explanation of benefits to determine amounts owed.
7. If you believe your insurance company has made an error with the processing of your claim, it is up to the policyholder to contact the insurance company to dispute, file a grievance and/or appeal. Please read your explanation of benefits,
8. You are ultimately responsible for payment of charges for services you received from our office.
9. **PATIENT BALANCES:** Payment is due for rendered services 30 days from receipt of your billing statement. Outstanding balances 60 days or older must be paid in full prior to any additional visit.
10. **NO SHOW APPOINTMENTS: A \$50.00 fee will be charged for any No Show appointments.**
11. **COLLECTIONS: Outstanding balances over 91 days old will be sent to the collection agency and charged additional fees.**
12. **BOUNCED CHECKS:** A \$45.00 fee will be charged for any check returned for insufficient funds. Your insurance company does not cover this fee. If this happens, payment will only be accepted by cash or credit card.
13. A scheduled appointment means that time has been reserved for you. Cancellations for appointments must be received at least 24 hours prior to the scheduled appointment.
14. Medical records requests must be received in writing. Fees for medical records are set in accordance with allowable amounts as defined by the State of Delaware. Fees must be received prior to record delivery.
15. Administrative Services: There is a \$65.00 charge for **each** required Administrative Service, payable prior to service completion. This Administrative Service Fee covers specific forms such as FMLA and Short Term Disability and is NOT covered by insurance.
16. In the event your insurance company should happen to send payment to you (the patient), you agree to forward said payment to our office to be applied to your account.
17. Our office accepts, cash, checks (post-dated checks **are not** accepted), and credit cards (Visa, MasterCard, Discover and American Express).
18. If you choose to contact Dr. Bell by text or email, Advantage Foot & Ankle Center is not responsible for any security breach.

I have read and understand the above Financial Policy for Advantage Foot and Ankle Center.

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(Signature of Patient, Parent or Legal Guardian (Must be 18 or older to sign))

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Date

# ADVANTAGE FOOT & ANKLE CENTER

## CONSENT TO TREATMENT

### ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Advantage Foot & Ankle Center Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

### AUTHORIZATION REGARDING PRIVACY POLICY

Due to the recent implementation of the Patient Privacy Act (HIPPA), I hereby authorize Advantage Foot & Ankle Center to:

1. Call \_\_\_\_\_ Home Phone \_(\_\_\_\_) \_\_\_\_\_ or \_\_\_\_\_ Cell Phone \_(\_\_\_\_) \_\_\_\_\_
2. Leave Detailed Message on Answering Machine \_\_\_\_\_ Yes / \_\_\_\_\_ No or Voicemail \_\_\_\_\_ Yes / \_\_\_\_\_ No
3. Speak with \_\_\_\_\_ Family Member(s) or Friend  
Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship \_\_\_\_\_
4. Appointment Reminders: 1. Call \_\_\_\_\_ Yes or \_\_\_\_\_ No

regarding the following: (1) Change Appointments, (2) Any pertinent information that may be relative to my care, and/or (3) Billing issues.

### ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICY

I acknowledge that I was provided a copy of the Advantage Foot & Ankle Centers Financial Policy and that I have read (or had the opportunity to read if I so chose), understand and will comply by the policies stated.

### CONSENT TO VIEW EXTERNAL PRESCRIPTION HISTORY

I authorize Advantage Foot & Ankle Center to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and Advantage Foot & Ankle Center and it may include prescriptions back in time for several years.

### PATIENT CONSENT

In order for Dr. Jason Bell to evaluate and treat the medical condition(s) I present, I authorize consent to allow for typical examinations, review of diagnostic testing, administration of medications, application of medical products, and all other pertinent care with reason of the practice of foot and ankle medicine. I agree to ask questions to clarify treatment should I not understand the treatment plan.

### INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Advantage Foot & Ankle Center all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I agree that should my account become delinquent and is referred to an attorney or collection agency for collection, I will be charged an additional fee of any unpaid balance at the time of referral for all costs of collection and attorney's fees. I authorize the use of my signature below on all insurance submissions.

Advantage Foot & Ankle Center may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

### DISCLOSURE OF SERVICES

I understand that Advantage Foot & Ankle Center is owned and operated by Dr. Jason Bell. During my course of treatment, products and/or services from this business may be recommended. I understand that I am under no obligation to patron these businesses and that I may find alternate sources to purchase these products and/or services.

I have read and fully understand this Consent to Treatment. This authorization is valid as of the date I have signed below and will remain in effect as long as I am a patient of Advantage Foot & Ankle Center. I have read this complete page and agree to all of its contents.

\_\_\_\_\_  
PRINT Name of Individual/Legal Representative

\_\_\_\_\_  
SIGNATURE of Individual/Legal Representative

\_\_\_\_\_  
Date

# ADVANTAGE FOOT & ANKLE CENTER COMPREHENSIVE MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## HISTORY OF PRESENT ILLNESS / WHAT BRINGS YOU IN?

What is your specific foot/ankle problem? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Which foot/ankle is involved?  Right  Left  Both

First visit to a doctor for this problem?  Yes  No

Have you had a similar problem in the past?  Yes  No

When did the problem begin? \_\_\_\_\_

How was the problem onset?  Sudden  Gradual

The problem is:  Improving  Worsening  Unchanged

The problem is worst:  AM  PM  At Rest  With Activity

What aggravates the problem? \_\_\_\_\_

What improves the problem? \_\_\_\_\_

Is the problem painful?  Yes  No If so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain:  Sharp  Dull  Aching  Throbbing  Cramping  Itching  Popping  
 Burning  Tingling  Clicking  Shooting  Stabbing  Other: \_\_\_\_\_

Describe previous treatments: \_\_\_\_\_

Is this from a Work Related injury?  Yes  No Is this from an Auto Accident?  Yes  No \_\_\_\_\_

## PAST MEDICAL HISTORY

Diabetes Type 1 2 Duration \_\_\_\_\_ years Last Blood Sugar \_\_\_\_\_ HbA1c \_\_\_\_\_

Acid Reflux  Liver Disease ( Hepatitis)

Anemia  Leg Cramps/Leg Pain at Rest

Anesthesia Complications  Lung Condition: \_\_\_\_\_

Arthritis ( Osteo /  Rheum)  Mitral Valve Prolapse/Murmur

Asthma  Multiple Sclerosis

Back Problems/Sciatica  Nervous Disorder/Depression

Blood Clot/DVT  Neuropathy

Cancer: \_\_\_\_\_  Osteomyelitis/Bone Infection

Cellulitis/Skin Infection ( MRSA?)  Pacemaker

Circulation Problem  Parkinson's Disease \_\_\_\_\_

Defibrillator  Previous Addiction to:

Dementia/Alzheimer's  Pulmonary Embolism

Dialysis  Rashes/Skin Condition

Excessive/Easy Bleeding  Raynauds Disease/Phenomena

Fibromyalgia  Seizure Disorder/Epilepsy

Foot/Leg Ulcer  Sickle Cell Disease/Trait

Gout  Sleep Apnea

Healing Problems/Keloids  Stomach Ulcers \_\_\_\_\_

Heart Disease/Heart Attack  Stroke  Rt  Lt year

High Blood Pressure ( Low BP?)  Thyroid Condition ( Hi  Lo)

Immune Disorder/HIV  Women – Are You...

Kidney Disease  Pregnant?

Breastfeeding?

## LIST ALL PREVIOUS SURGERIES

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## FAMILY HISTORY (circle relative)

**Mother Father Sister Brother GrandParent**

Cancer   M  F  S  B  GP  

Diabetes   M  F  S  B  GP  

Heart Disease   M  F  S  B  GP  

High Blood Pressure   M  F  S  B  GP  

Anesthesia Complications   M  F  S  B  GP  

Other: \_\_\_\_\_   M  F  S  B  GP  

Other problems not listed above: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# ADVANTAGE FOOT & ANKLE CENTER COMPREHENSIVE MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## MEDICATIONS: NAMES ONLY

ALL MEDICATIONS, INCLUDING VITAMINS AND OVER-THE-COUNTER, MUST BE WRITTEN ON THIS FORM - NO EXCEPTIONS

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## ALLERGIES

- |                                    |  |                                     |   |
|------------------------------------|--|-------------------------------------|---|
| <input type="checkbox"/> None      | <input type="checkbox"/> Adhesives/Tape    | <input type="checkbox"/> Iodine     | <input type="checkbox"/> Local Anesthetics: |
| <input type="checkbox"/> Aspirin   | <input type="checkbox"/> Aleve             | <input type="checkbox"/> Latex      | ___ Lidocaine ___ Epinephrine               |
| <input type="checkbox"/> Codeine   | <input type="checkbox"/> Cortisone         | <input type="checkbox"/> Motrin     | <input type="checkbox"/> OTHER: _____       |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Seafood/Shellfish | <input type="checkbox"/> Penicillin |   |
|                                    | <input type="checkbox"/> Sulfa Drugs       |                                     |   |

## SOCIAL HISTORY

Occupation: \_\_\_\_\_ / Percentage of time you Stand \_\_\_\_\_, Sit \_\_\_\_\_, and/or Walk \_\_\_\_\_ at work.

### TOBACCO HISTORY:

Do you currently use any Tobacco or Vape products? YES / NO / NEVER

Have you ever used any Tobacco or Vape products in the past? YES / NO / NEVER

Please Circle the Product(s) you currently used or have used:

Cigarettes / Cigars / Pipe / Hookah Pipe / Chewing Tobacco / Dipping Tobacco / Snuff / Vape

How long have you used Tobacco Product(s)? \_\_\_\_\_

Daily Usage Amount: \_\_\_\_\_

Have you tried to Quit Tobacco product(s)? YES or NO

### ALCOHOL HISTORY:

Do you currently drink Alcoholic beverage(s)? YES / NO / NEVER

Please Circle the type of Alcoholic beverage(s) you drink:

Beer / Wine / Hard Liquor

How often do you drink alcohol? \_\_\_\_\_

ILLEGAL DRUGS? YES / NO / NEVER

Do you seen Pain Management? YES / NO

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

## STATS

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

I understand that completing this paperwork is a chore. The information I have provided is true to the best of my knowledge. I recognize that the information I have provided will help me receive better care. I thank you for taking such an interest in my health.

X

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE (Must be 18 or older to sign)

\_\_\_\_\_  
DATE