ADVANTAGE FOOT & ANKLE CENTER

PATIENT REGISTRATION

PATIENT INFORMATION

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

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN ABOVE)

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

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.

_____ _____

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

_____

_____

When did the problem begin? _____

The problem is: ☐ Improving ☐ Worsening ☐ Unchanged

What aggravates the 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

How was the problem onset? ☐ Sudden ☐ Gradual

The problem is worst: ☐ AM ☐ PM ☐ At Rest ☐ With Activity

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
☐ Anemia
☐ Anesthesia Complications
☐ Arthritis (☐ Osteo / ☐ Rheum)
☐ Asthma
☐ Back Problems/Sciatica
☐ Blood Clot/DVT
☐ Cancer: _____
☐ Cellulitis/Skin Infection (☐ MRSA?)
☐ Circulation Problem
☐ Defibrillator
☐ Dementia/Alzheimer's
☐ Dialysis
☐ Excessive/Easy Bleeding
☐ Fibromyalgia
☐ Foot/Leg Ulcer
☐ Gout
☐ Healing Problems/Keloids
☐ Heart Disease/Heart Attack
☐ High Blood Pressure (☐ Low BP?)
☐ Immune Disorder/HIV
☐ Kidney Disease
☐ Liver Disease (☐ Hepatitis)
☐ Leg Cramps/Leg Pain at Rest
☐ Lung Condition: _____
☐ Mitral Valve Prolapse/Murmur
☐ Multiple Sclerosis
☐ Nervous Disorder/Depression
☐ Neuropathy
☐ Osteomyelitis/Bone Infection
☐ Pacemaker
☐ Parkinson's Disease _____
☐ Previous Addiction to:
☐ Pulmonary Embolism
☐ Rashes/Skin Condition
☐ Raynauds Disease/Phenomena
☐ Seizure Disorder/Epilepsy
☐ Sickle Cell Disease/Trait
☐ Sleep Apnea
☐ Stomach Ulcers _____
☐ Stroke ☐ Rt ☐ Lt year
☐ Thyroid Condition (☐ Hi ☐ Lo)
☐ Women – Are You...
☐ Pregnant?
☐ Breastfeeding?

LIST ALL PREVIOUS SURGERIES

_____
_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY (circle relative)

Mother **F**ather **S**ister **B**rother **G**rand**P**arent

☐ 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 MUST BE WRITTEN ON THIS FORM - DO NOT WRITE "SEE ATTACHED"

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

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES

☐ **None**

☐ Adhesives/Tape
☐ Aspirin
☐ Aleve
☐ Codeine
☐ Cortisone
☐ Ibuprofen

☐ Iodine
☐ Latex
☐ Motrin
☐ Penicillin
☐ Seafood/Shellfish
☐ Sulfa Drugs

☐ Local Anesthetics:
____ Lidocaine ____ Epinephrine
☐ OTHER: _____

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