Welcome to Foot/Ankle Clinic of Northern Cal.

New Patient Registration Form

Instructions: Please complete both sides. Print clearly, fill in all revelant information and sign on back.

PATIENT REGISTRATION INFORMATION

Patient's Full Name: _____ ☐ Female ☐ Male ☐ Single ☐ Married ☐ Widowd ☐ Separated ☐ Divorced

Date of Birth: Mo: _____ Day: _____ Year: _____ Age: _____

Social Security Number: _____ ☐ LeftHanded ☐ RightHanded

Address: Street: _____

City: _____ State: _____ Zip: _____

Home Phone Number: (_____) _____ Work & Alternate No. & Ext. (_____) _____
Area Code Area Code

Spouse/Significant Other's Name: _____

Do you have an Advanced Directive? ☐ Yes ☐ No Please provide original document

Person to call in an emergency: _____ Telephone No.: (_____) _____
Area Code

Responsible Party (for minor patient) _____

Name of Family/Primary Care Physician: _____

Were you referred to us by another ☐ Physician ☐ Person ☐ Patient? If so Name: _____

TODAYS VISIT

REASON FOR TODAY'S VISIT: _____

What Conditions or Symptoms are you experiencing? *Please describe pain below* Side of Body - ☐ Left ☐ Right

_____

_____

_____

_____

When did symptoms appear or date of Injury _____

_____

Is this Motor Vehicle Accident related? ☐ Yes ☐ No - If yes, when: _____

Is this Employment or Work related? ☐ Yes ☐ No If yes, date of Employment Incident _____

Was Symptom a result of an accident or fall? ☐ Yes ☐ No

If yes, Describe: _____

Is Pain Constant ☐ Yes ☐ No Describe Pain _____

Pain only when you move? ☐ Yes ☐ No _____

Was there or is there swelling? ☐ Yes ☐ No _____

Is there any history of this or a similar problem prior to the current condition or symptom? ☐ Yes ☐ No

If yes, Please describe: _____

_____

_____

_____

_____

_____

_____

PLEASE COMPLETE OTHER SIDE →

PATIENT MEDICAL INFORMATION

Do You: (Please Check Yes or No)

Yes	No		
☐	☐	Drink Coffee.....	How Often?
☐	☐	Use Tobacco Products.....	How Often?
☐	☐	Drink Alcoholic Beverages.....	How Often?
☐	☐	Exercise.....	How Often?
☐	☐	Recent Weight Change.....	Variation - Up /Down in Pounds
☐	☐	Are you pregnant?	
☐	☐	Have or have had Sexually Transmitted Disease	

FAMILY HISTORY

Please complete as much as possible relating to your Family History

Relation	*Deceased or Living*	*Age now or when Deceased*	*Medical Condition or Cause of Death*
Father			
Mother			
Brothers / Sisters			

PAST MEDICAL HISTORY

MEDICAL CONDITIONS - Please list ☐ **Cancer** ☐ **High Blood Pressure** ☐ **Diabetic**

PAST SURGICAL HISTORY Please list Date or approximate Age when occurred

LIST PREVIOUS FRACTURES - List bone(s) and approximate year fracture occurred

ALLERGIES - Please list all Allegies including Drug Allergies

MEDICATIONS - Please list ALL medicine/drugs patient is currently taking or recently took. Indicate dosage & frequency of the patient usage

Medicine / Drug Name	*Dose or Amount*	*Frequency (daily, weekly)*

Signature of Patient: _____ **Date:** _____

I hereby certify that the information disclosed herein is true and accurate to the best of my knowledge and that no material falsification or misrepresentaion has been made

Foot/Ankle Clinic of Northern Cal.

X _____(Initial) I understand Foot & Ankle Clinic of Northern Cal participates with my insurance. Any Co-Payments are due at the time services are rendered. Patients are responsiblefor deductibles, coinsurance amounts and any charges paid by insurance due to failure to present proper paperwork. Any referrals required by your plan are due at time of service. We make our best effort to inform you when new referrals are needed. However, it is your responsibility to be aware of your plan rules and keep track of your necessary approvals, including making sure your approved prior to receiving products and services. As a courtesy, this office will automatically file primary and secondary insurance claims. All insurance plans are different. Your plan may not cover certain products and services that are provided as part of our standard of care. You will be billed directly for such items. We will make our best effort to notify you in these instances, however it is impossible to know details of every insurance product available and frequent changes to those plans. Medicare requires an ABN, Advanced Beneficiary Notification. It is your choice and responsibility to refuse such items.

_____(Initial) I understand FACNC does not participate with my insurance plan. I am a self pay patient.
It is our policy to charge $100 deposit before receiving services, with the balance due at the end of your visit. Average visit charge is $200 to $300. We do offer a prompt payment discount. No Co-Pays apply. We will make a reasonable attempt to assist you with insurance claims, however, it is ultimately your responsibilty.

_____(Initial) I am utilizing my OUT-OF-NETWORK benefits.
Co-Pays or deposits do not apply. We will bill your insurance and will balance bill you any coinsurance and deductibles that apply. Patients are eligible for a prompt payment discount. All insurance plans vary, and some may not cover certain products and services that are provided as part of our standard of care. You will be billed directly for such items. We will make our best effort to notify you in these instances.

X _____(initial) I, the patient, authorize and request my insurance to pay directly to FACNC amounts due me under my policy as a result of medical care rendered by medical providers and staff associates at FACNC.

General Notice to All Patients. This office complies with HIPAA and CMS regulations.
Accounts not paid in accordance to terms of credit or incomplete financial arrangements will nullify any prior agrements. Physician services are provided to patients, not insurance companies, thus patients patient are responsible for charges for care received. If your insurance has delayed payment on clean claims past 120 days, balances will revert back to direct patient responsibility. Patients can then independently deal with their insurance. Patient balances due are payable within 60 days after the date of first invoice. A late fee of 1.5% monthly interest will be charged to delinquent accounts, commencing on the ninetieth (90th) day after first date billed. We may, at any time after 90 days from time of service received, turn delinquent accounts over to collections. Balances in collection are payable to our Collections Agent, and will include any agent fees in addition to our charges. Agent fees are typically 30% of the balance due, higher in some cases. All charges are subject to a chart and coding review prior to being finalized. Bills on demand are estimates only and should not be used for claims nor are considered final bills. Patient balances due are billed every 21 days. Accurate and complete insurance information, including changes, must be provided to registration at time of service. We will directly bill patients who fail to provide correct, timely information. We understand that unusual circumstances may arise and thatb payment in full at the time of service or post insurance payment may not always be possible. Patients must discuss special payment needs with our billing department. For your convenience, we, accept cash and checks, debit cards and most major credit cards.

Other Fees: Returned check fee is $25.00 per occurrence. A $3.00 per form fee, plus any postage applies to special forms. Examples of forms are rental assistance, private disability, credit card and mortgage plans. We require 48 hours turnaround time on forms. Due to HIPAA regulations, this office charges a reasonable fee for medical records of $1.00 per page and a $3.00 per film charge. Fees plus applicable postage on items requested must be paid in advance.

Third Party: Apparent or Guardian who brings a child/children in for treatment is responsible for payment. This office has nothing to do with the terms of divorce settlements; parents must settle between themselves. Thisn office does not accept letters of protection, nor do we bill third parties such as business or homeowner policies. It is our policy not to extend credit in such matters. We expect payment the day services are rendered. Patients can go after 3rd party reimbursements on their own.

FACNC is a participating Medicare provider and supplier. Standards are posted in our office and available by mail upon request. This office conducts business in accordance to a voluntary compliance plan. We will not comply with requests by patients that are considered fraud by the Government, US and/or N.J. For billing questions, please notify our billing department immediately. Representatives receive ongoing training and are available to answer your questions.

I hereby certify that I have read and understand this Foot & Ankle Clinic of Northern Cal financial policy. I agree to the terms stated herein.

Patient Signature_____ Date_____

Foot/Ankle Clinic of Northern Cal.

Acknowledgment of HIPPA Privacy Notice and Designation of Disclosure

1) Acknowledgment of Practice's Notice of HIPPA Privacy: I have received a copy of the Notice of HIPPA Privacy for the Physician Practice.

_____ _____ _____

Name of Patient Date of Birth Patient's Signature

11) Designation of Certain Relatives, Close Friends and Other Care givers:
A) I agree that the practice may disclose certain of my health information to a family member, close personal friend or other care giver, since such person is involved with my health care or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I wish to be contacted in the following manner (check all that apply):

TELEPHONE, WRITTEN AND FAX COMMUNICATION

Home Telephone Number:

_____

____ OK to leave message with detailed information
____ Leave message with call back number only

Written Communication Only:
____ OK to mail to my home address (such as postcards or letters)
____ OK to mail to my work or office address

Work Telephone Number:

_____

_____OK to leave message with detailed information
_____ Leave message with call back number only

Fax Communication:
____ OK to fax to this number: ( )_____-_____

B) I designate the following persons listed below as persons involved with my health care or payment relating to my healthcare for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name _____ Last 4 digits of SS #_____

Print Name_____ Last 4 digits of SS #_____

Print Name_____ Last 4 digits of SS #_____

Signature_____ Date _____