FOOT & ANKLE SPECIALISTS of DELAWARE COUNTY
A division of Pace Foot and Ankle

Patient Name: _____ **Social Security #:** _____
First MI Last

Home Address: _____
(Street) (City) (State, Zip Code)

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

Marital Status: circle: (Single) (Married) (Divorced) (Separated) (Widow(er)) **Primary Language Spoken**: _____

Date of Birth: _____ **Age:**_____ **Gender**: circle: (Male) or (Female)

How did you hear about the practice? circle: **E-mail**:_____

Google/Internet Friend/Family Insurance Facebook
Doctor Referral (who?) _____
Other _____

If Patient is a Minor (under18), Name of Parent or Guardian: _____

Patient's Employer:_____ **Occupation**: _____

Employer's Address: _____
(Street) (City) (State, Zip Code)

Emergency Contact: _____
(Name) (Relationship) (Phone)
Spouse/Partner Name:_____ **DOB**:_____ **Soc. Sec. #**_____

Spouse/Partner Employer:_____ **Spouse/Partner Work Phone**:_____

Spouse/Partner Employer Address:_____
(Street) (City) (State, Zip Code)
Family Doctor: _____**Phone Number**: _____**Last Visit**: _____

Reason for Visit to our Office : _____

Does patient smoke? circle one: (every day) (some days) (used to but quit) (never)

Height_____ **Weight**_____ **Most Recent Known Blood Pressure**_____/_____

Pharmacy Name & Phone #_____

PRIMARY INSURANCE: _____ ID#: _____

Name of Policyholder: _____ Relation to Patient: _____

Policyholder's Social Security No: _____ Policyholder's Date of Birth: _____

SECONDARY INSURANCE: _____ ID#: _____

Name of Policyholder: _____ Relation to Patient: _____

Policyholder's Social Security No: _____ Policyholder's Date of Birth: _____

SIGNATURE:_____ **DATE:**_____

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Name: _____ DOB: _____Date: _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
DIABETES	____	____	PHLEBITIS	____	____
HIGH BLOOD PRESSURE	____	____	REFLUX/ULCERS	____	____
HEART DISEASE	____	____	HEPATITIS A	____	____
HEART MURMERS	____	____	HEPATITIS B	____	____
ANGINA	____	____	HEPATITIS C	____	____
HIV/AIDS/ARC	____	____	SEIZURES	____	____
KIDNEY DISEASE	____	____	GOUT	____	____
LIVER DISEASE	____	____	TUBERCULOSIS	____	____
LUNG DISORDERS	____	____	BACK PROBLEMS	____	____

PLEASE LIST ANY MEDICAL CONDITIONS PAST OR PRESENT NOT LISTED ABOVE:

_____

_____

_____

FAMILY HISTORY

YES	NO	RELATIONSHIP	YES	NO	RELATIONSHIP
___	___	Diabetes _____	___	___	Blood Diseases _____
___	___	Heart Disease _____	___	___	Familial Hereditary Conditions _____
___	___	Cancer _____	___	___	Surgical Complications _____
___	___	Hypertension _____	___	___	Other _____

PLEASE LIST ANY HOSPITALIZATIONS AND/OR SURGERIES, AND THE YEAR:

_____

_____

_____

PLEASE LIST PRESENT MEDICATIONS AND DOSAGES:

_____

_____

_____

PLEASE LIST ANY ALLERGIES YOU HAVE: _____

_____

_____

SOCIAL HISTORY:

	YES	NO	HOW MUCH?
DO YOU SMOKE?	___	___	_____
DO YOU DRINK ALCOHOL?	___	___	_____

Signature/Guardian: _____

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- If the office does not participate with or except assignment from your health insurance, payment in full will be due at the time of service unless prior arrangements have been made.

- Office visit co-payments for our participating HMO/PPO insurances are due at the time of service. If we have to generate a billing statement to collect your co-payment there will be a minimum billing fee of $5.00 added for the administrative costs of billing.

- If we are a participating provider with your primary health insurance, we are happy to file a claim on your behalf. However, once the insurance company is billed we allow 60 days for the balance to be paid by your insurance carrier. If the insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance, we will refund the overpayment to you within 30 days, providing that you do not have any outstanding accounts with our office.

- HMO/PPO claim denials due to no referral or authorization are the patient's responsibility. Our office staff will notify and assist you in referral/precertification procedures, but final responsibility lies with the patient to comply with their specific insurance's requirements. All referrals must be presented to our receptionists before seeing the doctor.

- Please notify our receptionists or billing office if there is any change in your insurance, otherwise your visit may not be covered and you will be responsible for payment.

- There is a $25.00 charge for all returned checks.

- All unpaid balances are subject to 1.5% interest or minimum $5.00 service charge after 90 days

- If your account must be forwarded to a collection service and/or an attorney because of non-payment, you will be responsible for all collection fees and/or attorney fees charged by these services.

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) have insurance coverage that will pay for my medical care and assign directly to **Foot & Ankle Specialists of Delaware County, Dr. Samuel and Associates.** I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. 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.

By my signature I acknowledge receipt of a copy of this policy and hereby agree to its terms.

Patient or Guardian: _____Date: _____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature