HEARTLAND
FOOT & ANKLE ASSOCIATES
www.HeartlandFootAndAnkle.com (309) 661-9975

DEMOGRAPHICS & INSURANCE

Patient Information

Name: _____
(First) (MI) (Last)

SS#:_____ DOB:_____ Sex: □ Male □Female

Email:_____ Street Address:_____

City, State, Zip Code:_____

Preferred Phone Number: _____Other Phone Numbers:_____

Appointment confirmation calls will always be made to the preferred phone number and a message with your appointment details will be left.

Primary Care Physician: _____ Date of Last Visit: _____

Referring Physician: _____ Date of Last Visit: _____

Emergency Contact: _____
(Name) (Phone)

Primary Language: □ English □Spanish □Other Ethnicity: □Hispanic/Latino □not Hispanic/Latino

Race: □American Indian/Alaska Native □Asian □Black/African American □Hawaiian/ Pacific Islander □White

Are you a student: □Yes □No Marital Status: □ S □ M □ D □W

Financially Responsible Party Information (if different than patient)

Name: _____ Relationship:_____
(First) (MI) (Last)

SS#:_____ DOB:_____ Phone Number: _____

Address: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance:_____

Insurance Subscriber Information (if different than patient)

Name: _____SS#:_____ DOB:_____ Relationship:_____
(First) (MI) (Last)

Authorization to Disclose Health Information

By selecting appointment information this individual has the right to confirm, change, and cancel appointments, as well as know all past appointment history.

Name:_____ Relationship:_____
May disclose (select all that apply): □ Billing Information □Medical Information □Appointment Information

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MEDICAL HISTORY

Reason for Visit: _____

How did you hear about the office? _____ Shoe Size: _____ Height: _____ Weight: _____

PQRS (Physician Quality Reporting System) Questions:

Have you experienced 2 falls OR any falls with injury in the last year: □Yes □No
Have you received an influenza vaccination this year? □Yes □No
Have you received a pneumonia vaccination this year? □Yes □No
Do you drink caffeinated beverages (soda, coffee, tea): □Yes □No If so, how many drinks per day: _____
Do you drink alcoholic beverages: □Yes □No If so, how many drinks per day: _____
Do you smoke: □No □<5 cigarettes per day □½ pack per day □1 pack per day □>1 pack per day

Marital Status: □Married □Single □Widowed □Divorced □Separated
Who do you live with: □Spouse □Alone □Children □Significant Other □Parents
Employment Status: □Employed □Unemployed □Disabled
Occupation (current or former):_____ How many children do you have:_____

Allergies: (please check those that apply or provide a list to copy)

□Penicillin □Iodine □Aspirin □Adhesive Tape □Sulfa
□Codeine □Seafood/Shellfish □Local Anesthetics □Other_____

Current Medications: Prescription and Non-Prescription (Or provide a list to copy)

_____
_____

Past Surgical History:

_____
_____

Past Medical History: (Please check all that apply)

□Anemia □Bleeding Disorders □Hepatitis □Lung Problems □Stroke
□Arthritis □Diabetes □High Blood Pressure □Neck Pain □Cancer
□Asthma □Gout □Kidney Problems □Numbness in Feet □Other
□Back Pain □Heart Disease □Liver Disease □Poor Circulation

Mother's Medical History: (Please check all that apply)

□Anemia □Bleeding Disorders □Hepatitis □Lung Problems □Stroke
□Arthritis □Diabetes □High Blood Pressure □Neck Pain □Cancer
□Asthma □Gout □Kidney Problems □Numbness in Feet □Other
□Back Pain □Heart Disease □Liver Disease □Poor Circulation

Father's Medical History: (Please check all that apply)

□Anemia □Bleeding Disorders □Hepatitis □Lung Problems □Stroke
□Arthritis □Diabetes □High Blood Pressure □Neck Pain □Cancer
□Asthma □Gout □Kidney Problems □Numbness in Feet □Other
□Back Pain □Heart Disease □Liver Disease □Poor Circulation

I hereby give my permission to the doctor(s) at Heartland Foot and Ankle Associates, P.C. to perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in diagnosis and/or treatment of my feet and/or ankles.

PATIENT SIGNATURE: _____ DATE: _____

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FINANCIAL POICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. We accept Medicare benefit amounts. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for full payment of these services at the time of service.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: ***All co-payments, co-insurance, or deductible amounts must be paid AT THE TIME OF SERVICE.*** This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion of insurance benefits at each visit. As a courtesy, our office does verify benefits with your insurance carrier; however, the insurance agreement is a contract between you and your insurance carrier. It is recommended that you verify your benefits with your carrier as well.

PHYSICIAN PHONE CALLS: Phone calls with our physician(s) are a billable service, may be billed to your insurance company/companies, and are subject to your insurance benefits. You are responsible for your portion of insurance benefits for physician phone calls.

NON-CUSTOM DURABLE MEDICAL EQUIPMENT RETURNS: If a patient is unsatisfied with any non-custom Durable Medical Equipment item, it must be returned within 30 days per Medicare guidelines. Returns after 30 days will not be permitted. The item will only be accepted as a return if it is in returnable condition. Any custom durable medical equipment item may not be returned for any reason.

COPY FEE: We will provide copies of patient records at the patient's request. Copies of records may be subject to a $0.05 per single page copy fee. You will bear complete financial responsibility for any fee(s) incurred.

CANCELLED/MISSED APPOINTMENT FEE: If you cannot keep your appointment time, please call our office at least 60 minutes prior to your scheduled appointment time. There may be a **$25 fee** for any appointment cancelled or rescheduled within 60 minutes of the scheduled time. Additionally, there may be a **$25 fee** if you miss a scheduled appointment. If you miss 3 or more appointments, you may be required to pay a $50 deposit to hold any future appointment time slots. If you arrive late for an appointment, we may need to reschedule your appointment. You will bear complete financial responsibility for any fee(s) incurred. Repeated missed or late appointments may result in dismissal from our practice.

COLLECTIONS FEE: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account will be forwarded to our collection agency. If your account is sent to a collections agency, a **35% fee** will be added to your account. You bear complete financial responsibility for any fee(s) incurred.

Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA/MasterCard/Discover. An additional $25.00 will be added to your statement if the check is returned from your bank. We do not accept starter checks. In the event that your insurance company sends payment to you, the patient, it should be forwarded to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* to Heartland Foot and Ankle Associates, P.C. for medical services provided. I agree to pay Heartland Foot and Ankle Associates, P.C. any balance unpaid by my insurance carrier for myself or the below named person.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to its terms.

Assignment of Benefits
I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Heartland Foot and Ankle Associates, P.C.** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees **AT THE TIME OF SERVICE**. 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.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms:

PRINT Patient Name: _____ Signature: _____

If patient is under 18, please complete the following for the *FINANCIALLY RESPONSIBLE PARTY*:
PRINT Name: _____ Signature: _____
Relationship to Patient: _____ Date: _____