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

DEMOGRAPHICS & INSURANCE

*Name: _____
(First) (MI) (Last)
*SS#:_____ *DOB:_____ *Sex: □ M □F
REQUIRED FOR INSURANCE
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: _____

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? _____ 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 a COVID vaccination this year? □Yes □No Booster? □Yes □No
Have you received an influenza vaccination this year? □Yes □No
Have you received a pneumonia vaccination this year? □Yes □No
Do you have a living will or advanced directive? □Yes □No
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

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

□Penicillin □Iodine □Aspirin □Adhesive Tape □Sulfa
□Codeine □Seafood/Shellfish □Local Anesthetics □Other_____
List reactions, if any allergies: _____

Current Medications: Prescription and Non-Prescription (Or **PROVIDE A LIST**)

_____
_____
_____

Past Surgical History (Please check all that apply):

□ Appendix Removal
□ Bypass Surgery
□ C – Section
□ Cardiac Stents
□ Carpal Tunnel Surgery
□ Gallbladder Removal
□ Hernia Repair
□ Hip Replacement
□ Hysterectomy
□ Knee Replacement
□ Lower Back Surgery
□ Neck Surgery
□ Shoulder Surgery
□ Sinus Surgery
□ Tonsil Removal
□ Wisdom/Tooth Removal
□ Other_____
_____

Past Medical History: (Please check all that apply)

	You	Mother	Father		You	Mother	Father
Anemia	□	□	□	Hepatitis	□	□	□
Arthritis	□	□	□	High Blood Pressure	□	□	□
Asthma	□	□	□	Kidney Problems	□	□	□
Back Pain	□	□	□	Liver Disease	□	□	□
Bleeding Disorders	□	□	□	Lung Problems	□	□	□
Cancer_____	□	□	□	Neck Pain	□	□	□
Diabetes	□	□	□	Numbness in Feet	□	□	□
Gout	□	□	□	Poor Circulation	□	□	□
Heart Disease	□	□	□	Other_____	□	□	□

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.

PRINT Patient Name: _____ Date:_____

Signature: _____

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FINANCIAL & PRIVACY POLICIES

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 allowed for. 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 a service.

SECONDARY INSURANCE: As a courtesy, 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.

INSURANCE APPEALS PROCESS: Heartland Foot and Ankle Associates makes every attempt to verify your insurance benefits prior to treatment. At times, benefits provided by your insurance carrier do not align with how they process claims. If your insurance claim is denied, an appeal will be filed on your behalf by Heartland Foot and Ankle Associates. Please know that all charges are ultimately the patient's responsibility regardless of the appeals process and as such any outstanding balance must be paid in full within 120 days of the initial date of service.

PATIENT BILLING: ***ALL CO-PAYMENTS, CO-INSURANCE, AND/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.**

Patient Initials _____

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.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan. When you visit a specialist, you may need a referral from your primary care physician or your insurance company 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 or insurance at the time of a visit, and one is required, 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.

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

PRODUCTS: Payment in full is due at the time of service as products are an over-the-counter collection. If you have a health savings account in a card form, it can be collected for payment. ***Insurance will not pay for this.***

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be allowed for 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.

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.

MEDICAL RECORDS 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 24 hours prior to your scheduled appointment time*. **THERE MAY BE A $50 FEE FOR ANY APPOINTMENT CANCELLED OR RESCHEDULED WITHIN 60 MINUTES OF THE SCHEDULED TIME.** Additionally, there may be a $50 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 15 MINUTES OR LATER FOR YOUR 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**.

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. If 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.

MARKETING STATEMENT: By signing my name below, I consent to being sent periodic electronic mail and/or SMS messages that may be of interest to me based on my diagnosis or for general informational purposes**. If you DO NOT wish to receive these communications, please initial here _____.**

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 signing 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.

Patient Initials _____

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: _____