Arch Advantage
FOOT AND ANKLE CENTER

Patient Questionnaire and Release Forms

Patient Name _____ DOB _____
Address _____
City _____ State _____ Zip _____
Cell Phone _____ Social Security# _____
Home Phone _____ Email Address _____
Work Phone _____

Marital Status Single ☐ Married ☐ Divorced ☐ Widowed ☐

Emergency Contact _____ Relation to patient _____
Phone Numbers _____

Family Physician/Internist: _____
Phone: _____
Preferred Pharmacy _____
Phone: _____

Insurance Information

Primary Insurance Company Name: _____
Insurance Subscriber's Name: _____ Subscriber's DOB: _____

Secondary Insurance Company Name: _____
Insurance Subscriber's Name: _____ Subscriber's DOB: _____

Responsible Party (if other than patient): _____
Responsible Party's Name: _____ DOB: _____

Do you have an HMO insurance? Y ☐ N ☐
If yes, you must have your referral or your appointment will need to be rescheduled.

I authorize Dr. Cathy Coker/ Arch Advantage Foot and Ankle Center to release any medical information necessary to process my insurance claim, and I authorize payment of medical benefits to be made to this practice for services rendered. I agree to pay all of my copays, coinsurance, deductibles, and any balance that is denied or in dispute by my insurance company.

SIGNATURE: _____ DATE: _____
Patient, parent, or responsible party

MEDICAL HISTORY

Anemia	Y ☐	N ☐	Heart Catheterization	Y ☐	N ☐
Arthritis (osteo)	Y ☐	N ☐	Heart Problems	Y ☐	N ☐
Asthma	Y ☐	N ☐	Hepatitis A / B / C	Y ☐	N ☐
Blood clots	Y ☐	N ☐	Hernia	Y ☐	N ☐
Blood Transfusion	Y ☐	N ☐	Kidney Problems	Y ☐	N ☐
Cancer	Y ☐	N ☐	Liver Disease	Y ☐	N ☐
Congestive Heart Failure (CHF)	Y ☐	N ☐	Meningitis	Y ☐	N ☐
Cholesterol	Y ☐	N ☐	Migraines	Y ☐	N ☐
Diabetes	Y ☐	N ☐	Multiple Sclerosis	Y ☐	N ☐
Emphysema	Y ☐	N ☐	Paralysis	Y ☐	N ☐
Epilepsy	Y ☐	N ☐	Polio	Y ☐	N ☐
Fibromyalgia	Y ☐	N ☐	Rheumatoid Arthritis	Y ☐	N ☐
Foot/Skin Ulcers	Y ☐	N ☐	Scoliosis	Y ☐	N ☐
Gall bladder problems	Y ☐	N ☐	Seizures	Y ☐	N ☐
High Blood Pressure	Y ☐	N ☐	Stomach/Intestinal Ulcer or Bleeding	Y ☐	N ☐
Head Injury	Y ☐	N ☐	Stroke	Y ☐	N ☐
Hearing Loss	Y ☐	N ☐	Tuberculosis	Y ☐	N ☐
Heart Attack	Y ☐	N ☐	Thyroid Problem	Y ☐	N ☐
			Weakness	Y ☐	N ☐

DO YOU HAVE ANY MEDICAL PROBLEMS NOT LISTED ABOVE? (Please list) _____

ALLERGIES:

Do you have any allergies to any medications? Y ☐ N ☐

If Yes, Please List _____

Do you have any allergies to adhesives? Y ☐ N ☐

If Yes, Please List _____

Any allergies to Betadine/iodine/shellfish? Y ☐ N ☐

If Yes, Please List _____

Any other allergies not listed? _____

SURGICAL HISTORY:

Please list the type of surgery and approximate year of your surgery/surgeries: _____

MEDICATIONS:

Please list your medications and dosage (or provide a list) , including OTC & herbal, etc.: _____

SOCIAL HISTORY

Is there any chance that you could be pregnant? Y ☐ N ☐
If female, date of last menstrual period? _____

Do you smoke? Y ☐ N ☐ If yes, how much? _____ How Long? _____
Have you quit smoking? Y ☐ N ☐ If yes, when?
Do you drink alcohol? Y ☐ N ☐ If yes, how much? _____ How Often? _____
Use recreational drugs? Y ☐ N ☐ If yes, what type? _____

Do you use any assisted devices? Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐

Are you currently working? Y ☐ N ☐ Occupation _____
If "no" above, please explain why _____

Your height? _____ Ft. _____ In. Weight: _____ Lbs. Shoe size? _____

FAMILY History: (please CHECK any condition(s) that your immediate family (grandparents, mother, father, siblings, children) suffer(ed) from and their relationship to you:

☐ Blood clots Relationship to you? _____

☐ Blood disorder Relationship to you? _____

☐ Cancer / What Type? _____ Relationship to you? _____

☐ Diabetes Relationship to you? _____

☐ Heart disease Relationship to you? _____

CHIEF COMPLAINT: what is the reason that prompted you to make this appointment?

_____

_____

_____

How long has this problem/symptom(s) been present? _____

Have you tried or received any prior treatment for this condition? Y ☐ N ☐
If "yes" please explain: _____

Patient name printed: _____ Date: _____

Patient/Guardian Signature _____

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

1 Acknowledgement of Practice's Notice of Privacy Practices:
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

_____ _____ _____
Patient Name (printed) *Date:* *Patient/Guardian Signature*

2 Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:
I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such a person is involved with my health care or payment relating to my health care. 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.

Name (printed) _____ Phone Number _____

Name (printed) _____ Phone Number _____

Name (printed) _____ Phone Number _____

3 Request to Receive Confidential Communications by Alternative Means:
As provided by Privacy Rule Section 154.522(b), I hereby request that Practice make all communications to me by the alternative means that I have listed below.

Home telephone number _____
- ☐ Okay to leave message with detailed information
- ☐ Okay to leave message with call back numbers only

Work telephone number _____
- ☐ Okay to leave message with detailed information
- ☐ Okay to leave message with call back numbers only

Mobile telephone number _____
- ☐ Okay to leave message with detailed information
- ☐ Okay to leave message with call back numbers only

Email address _____
- ☐ Okay to leave message with detailed information
- ☐ Okay to leave message with call back numbers only

Other Instructions _____

_____

_____

_____ _____ _____
Patient Name (printed) *Date:* *Patient/Guardian Signature*

_____ _____ _____
Witness Name if applicable (printed) *Date:* *Witness Signature*

Financial Policy

Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsibly party is responsible for their bill being paid in full. Please inform us at every visit of any changes to your insurance coverage.

COPAYMENTS: It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor.

DEDUCTIBLES & CO-INSURANCE: If you have a high deductible plan, we may collect a $125 deposit to apply towards your deductible and co-insurance. Any remaining balance after submission to your insurance company is your responsibility.

SELF-PAY: (for non-covered products and services and for patients without insurance coverage): Full payment is due at time of service. A down-payment will be required before seeing the doctor. At a minimum, an evaluation and management fee will be charged. Additional procedures/services may be recommended by the doctor. You will be informed of these charges before proceeding with treatment.

REFERRAL: If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we may need to reschedule your appointment.

NO SHOW: (failure to present for your appointment): 24 hours-notice is required for cancellation of your appointment and failure to do so will incur a $50 fee. Failure to provide 24 hours-notice for a scheduled office procedure will incur a
$100 fee.

SURGERY CANCELLATION: Failure to provide 5 business-days' notice before surgery will incur a $450 fee.

BALANCES/COLLECTION FEES: If payment of an outstanding balance is not received within 30 days from the postmark date of a mailed statement or e-statement time stamp, a $10 re-billing fee may be added to each additional statement. Our patient portal offers the ability to view statements and submit payments conveniently and securely. Patients with balances more than 90 days overdue will be turned over to collections and a $35 administrative fee will be applied.

RETURN CHECK FEE: A $35 fee will be assessed for all returned checks

FMLA/DISABILITY/MEDICAL RECORDS: There is a $30 charge for having the doctor complete these forms. Requested forms will be completed within 5-7 business days of diagnosis and care plan. There is a $30 fee to obtain a copy of your medical records.

I have read and understand these financial policies.

Patient Name (printed)	*Date of Birth:*
Patient/Guardian Signature	*Date:*