Carolina Foot & Ankle Specialists, PA

2391 Court Drive, Suite 100

Gastonia, NC 28054

704-867-7388

Financial Policy

This financial policy contains important information about billing and payment for our professional services. It outlines our responsibilities and yours.

- Payment for professional services can be made by cash, check, credit card or debit card. We accept Visa, Master Card, American Express and Discover Card.
- Please note that we no longer Bill patients for Unpaid balances: Co-pays, deductible, or Co-insurance amounts. **One of the above payment options must be selected.**
- Our practice participates with most health insurance companies and managed care programs. We participate with both Medicare and Medicaid. Our Billing Company will submit a claim for any service rendered to you if you are a member of one of these plans.
- You must provide all necessary insurance information and complete any required forms before leaving the office. **Your current insurance card (s) will be copied at each and every visit**
- It is your responsibility to make payment at the time of service for any and all copayments or coinsurance amounts that are due. Any services not covered by your insurance plan are your responsibility and payment in full is expected at the time of service (one of the above payment options must be selected). Failure to make a Co-Payment on the day of service is putting you in jeopardy of breaking your contract with your insurance company.
- It is your responsibility to ensure that any required authorization or referral for treatment is obtained **prior to the visit.** In the absence of a required authorization or referral, your visit may be rescheduled or you may be personally responsible for payment for the services rendered.
- If you are a member of an insurance plan with which we do not participate, our office will file the claim on your behalf; you will be expected to make payment in full at the time of the service.
- Carolina Foot & Ankle Specialists, PA makes every effort to verify benefits prior to each visit. We attempt to confirm the deductible you have paid and what is still outstanding to the date of the visit. However, it is your ultimate responsibility to understand any benefit limitations, restrictions or authorizations requirements of your particular plan. Insurance plans rarely cover all services or pay the entire amount of those they do cover.

Carolina Foot & Ankle Specialists, PA

2391 Court Drive Suite 100
Gastonia, NC 28054
Phone (704) 867-7388 Fax (704)865-8999

Patient Name____

Date of Birth_____/______/______ Phone # ______________________

CHARGES FOR MISSED APPOINTMENTS:

Effective April 4, 2017 the policy of Carolina Foot & Ankle Specialists, PA is that patients missing scheduled appointments for office visits or procedures will bill charged a **MISSED APPOINTMENT FEE.** This policy applies equally to all patients (Medicare, Medicaid and Commercial.) If the responsible party fails to pay the fee prior to next visit, the unpaid fee will be collected at that time, along with the required co-pays and other patient due balances. After two missed appointments, you will not be able to schedule an appointment until fees are paid.

CANCELLATION OR NO-SHOW POLICY:

Please understand that when you do not cancel an appointment you are unable to keep, it may prevent other patients from receiving care they need. Therefore, we charge a $25.00 fee for appointments not cancelled within 24 hours. A patient who fails to keep three appointments in a twelve month period without a 24 hour notice may be subject to discharge from Carolina Foot & Ankle Specialists.

__________________________ __________________________

Patient Signature/Patient Representative **Print Name**

__________________________ __________________________

Relationship to Patient **Date**

Carolina Foot & Ankle Specialists
2391 Court Drive #100
Gastonia, NC 28054
Phone: 704-867-7388 Fax: 704-865-8999

Patient Name: ____________________ **DOB:** ____________ **Age:** __________ **Gender: M / F**

Address: ____

City: ______________ State: __________ Zip: ____________

Phone Number: ______________________ Cell / Home / Work

E-mail: ______________________________ **SS#:** _____--______--______

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Primary Care Doctor: ______________________________________

Does your Primary Care Doctor Know You Are Here? ______________________

Emergency Contact:

Name: ______________________ Relationship to patient: ______________________

Phone Number: __________________ Cell / Home / Work

Employment Information

Employer Name: ______________ Occupation: ______________ Phone Number: ______________

- Is Insurance through this employer? ◯ Yes ◯ No

Please describe what foot or ankle problem(s) you are having that brought you into our office today or choose from one of the following:

____

____

____

◯Flat Feet ◯Heel or Arch pain ◯Burning in toes/feet

◯Pain/Fatigue of feet/legs with activity ◯Achilles tendon pain ◯Numbness/Tingling in feet/toes

◯Ankle swelling/stiffness ◯Ankle Instability ◯Discoloration of toes/feet

◯Pain in feet getting out of bed ◯Coldness in feet ◯Slow healing sores on foot/ankle

◯Poor Coordination/ Balance/Falling ◯Other: ________________

How long has it bothered you? _____Days / _____Weeks / _____Months / _____Years

Does the pain interfere with your daily activities? ◯YES ◯NO

If Female, are you or could you be pregnant? ◯ YES ◯NO

Past Surgical History: (I.E. Appendectomy-Dr. Apex- 2001):

____

____

____

____

Patient Name: ______________________________ Date of Birth: _______________

Past Medical History: (Check ALL that apply)

- ◯ **None of the following**
- ◯ Anemia
- ◯ Arthritis
- ◯ Asthma
- ◯ Blood Clots
- ◯ Shortness of Breath
- ◯ Circulation Problems
- ◯ Congestive Heart Failure
- ◯ Cancer: ____________
- ◯ Diabetes
- ◯ Fracture, Where? _______
- ◯ Poor Circulation
- ◯ High Blood Pressure
- ◯ Gout
- ◯ Heart Valve Disease/Replacement
- ◯ Hepatitis
- ◯ HIV/AIDS
- ◯ High Cholesterol
- ◯ Hyperthyroidism
- ◯ Hypothyroidism
- ◯ Lung Disease: ____________
- ◯ History of MRSA
- ◯ Neuropathy
- ◯ Respiratory Problems
- ◯ Migraines
- ◯ Hiatal Hernia
- ◯ Epilepsy/Seizures
- ◯ Sickle Cell
- ◯ Stroke
- ◯ Bladder Problems
- ◯ Kidney Problems/Dialysis
- ◯ Stomach Ulcer
- ◯ Varicose Veins
- ◯ Vascular Disease
- ◯ Glaucoma
- ◯ Hearing Impaired
- ◯ Swelling in Feet, Ankles
- ◯ Other: __________________________

Family History: List any family member(s) who have or had any of the listed conditions

Arthritis: ______________________________ High Blood Pressure: ______________________

Heart Disease: ___________________________ Circulation Problems: _____________________

Gout: __________________________________ Diabetes: ______________________________

Stroke(s): ______________________________ Asthma/Respiratory Disease(s): _______________

Allergies: ◯ None ◯ Codeine ◯ Latex ◯ Lidocaine ◯ Penicillin ◯ Sulfa Drug ◯ Other: ________________

Medications: List Below or Attach Separate List

Drug Name	Strength (mg)	How Often?	Prescribed by?

Smoker Status: ◯ Current everyday ◯ Current some-day ◯ Former smoker ◯ Never smoker

Alcohol use: ◯ Never ◯ Socially ◯ Daily ◯ Weekly ◯ Former

Do you walk with a: ◯ Cane ◯ Walker ◯ Crutches ◯ Non-ambulatory ◯ None

Patient's Height: __________ **Weight:** _________ **Shoe Size:** _________ **Shoe Width:** _________

Pharmacy: ______________________________ **Phone:** ______________________________

Address: ______________________________

Carolina Foot & Ankle Specialists, PA
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Gastonia, NC 28056
Phone: 704-867-7388 Fax: 704-865-8999

Review of Systems:

Patient Name: ______________________________ **Date of Birth:** ____________________

Check ALL that apply if you currently suffer from the following or have had in the past:

General-
- ☐ Fatigue
- ☐ Fever or Chills
- ☐ None
- ☐ Weakness
- ☐ Trouble Sleeping

Skin-
- ☐ Rashes
- ☐ Lumps
- ☐ Itching
- ☐ Hair/Nail Changes
- ☐ Dryness
- ☐ Color Changes
- ☐ None

Head-
- ☐ Headaches
- ☐ Head Injury
- ☐ Neck Pain
- ☐ None

Ears-
- ☐ Decreased Hearing
- ☐ Earache
- ☐ Ringing in Ears
- ☐ None

Eyes-
- ☐ Vision Loss/Changes
- ☐ Glasses or Contacts
- ☐ Pain
- ☐ Redness
- ☐ None
- ☐ Blurry or Double Vision
- ☐ Specks
- ☐ Cataracts

Nose-
- ☐ Hay Fever
- ☐ Nosebleeds
- ☐ Sinus Pain
- ☐ Painful Breathing
- ☐ Wheezing
- ☐ None

Respiratory-
- ☐ Cough
- ☐ Coughing up Blood
- ☐ Shortness of Breath
- ☐ None

Hematologic-
- ☐ Ease of Bruising
- ☐ Ease of Bleeding
- ☐ None

Cardiovascular-
- ☐ Chest Pain or Discomfort
- ☐ Tightness
- ☐ None
- ☐ Palpitations
- ☐ Shortness of Breath With Activity

Gastrointestinal-
- ☐ Swallowing Difficulties
- ☐ Rectal Bleeding
- ☐ None
- ☐ Heartburn
- ☐ Constipation
- ☐ Nausea
- ☐ Diarrhea
- ☐ Change in Bowel Habits
- ☐ Yellow Eyes or Skin

Vascular-
- ☐ Calf Pain with Walking
- ☐ Leg Cramping
- ☐ Swelling
- ☐ None
- ☐ Cold Feet, Hands

Musculoskeletal-
- ☐ Muscle or Joint Pain
- ☐ Stiffness
- ☐ Swelling of Joints
- ☐ Back Pain
- ☐ None
- ☐ Redness of Joints

Neurologic-
- ☐ Dizziness
- ☐ Numbness
- ☐ Fainting
- ☐ Tingling
- ☐ Seizures
- ☐ Tremor
- ☐ Weakness
- ☐ None

Endocrine-
- ☐ Heat or Cold Intolerance
- ☐ Sweating
- ☐ Frequent Urination
- ☐ Thirst
- ☐ Change in Appetite
- ☐ None

Psychiatric-
- ☐ Nervousness
- ☐ Memory Loss
- ☐ Stress
- ☐ None
- ☐ Depression

Patient Signature: ______________________________

Date: ______________________________

PATIENT HIPAA ACKNOWLEDGEMENT - DESIGNATION AND DISCLOSURE FORM

I. 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.

________________________ ________________ ______________________________

Name of Patient **Date of Birth** **Signature of Patient/Parent/Guardian** **Date**

II. 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 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.

Print Name:________________________ **Last four digits of his/her SSN (required):**__________

Print Name:________________________ **Last four digits of his/her SSN (required):**__________

Print Name:________________________ **Last four digits of his/her SSN (required):**__________

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number:

____

____ OK to leave message with detailed information

____ Leave message with call back numbers only

Work Telephone Number:

____

____ OK to leave message with detailed information

____ Leave message with call back numbers only

Written Communication Address:

____

____ OK to mail to address listed above

____ E-mail me at:______________________

Fax Communication:

____

____ OK to Fax at the number listed above

____ E-mail me at:______________________

Other:____

IV. The following person(s) <u>are not authorized</u> to receive my Patient Health Information (PHI):

Print Name:________________________ **Print Name:**________________________

Print Name:________________________ **Print Name:**________________________

V. The HIPAA Privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary health care activities related to providing patient treatment, obtaining payment for its services or its internal operations. Also, the Practice does not have to account for disclosures for which I have executed an Authorization permitting disclosures of my PHI.

Date of disclosure request	Disclosed to whom: address/fax	Description of disclosure	Purpose of disclosure	Dates of Service of disclosure	Person completing request	Date completed