Foot and Ankle CENTER
a division of PACE FOOT AND ANKLE CENTERS

Demographic Insurance Info

931 E. Haverford Road, 3rd Floor, Bryn Mawr, PA 19010 • 610.642.5040 • FootAndAnkleCenterOnline.com

Last Name_____ First Name_____ Middle Initial_____

Street Address _____

City_____State_____ Zip Code _____

E-mail Address_____

Phone Numbers: Home_____ Work_____ Cell _____

Date of Birth_____/_____/_____ Age_____ Social Security Number_____

Marital Status: ❑ Single ❑ Married ❑ Partner ❑ Divorced ❑ Widow(ed) ❑ Legally Separated Sex: ❑ M ❑ F

Student Status: ❑ Full Time ❑ Part Time

Employer Name_____

Street Address_____

City_____State_____ Zip Code_____ Phone Number_____

Insurance Subscriber Name_____ Social Security #_____Date of Birth_____/_____/_____

Pharmacy_____

I was referred to this office by:_____

Family/Primary Physician _____Date Last Seen_____/_____/_____

Street Address_____

City_____State_____ Zip Code_____ Phone Number_____

Emergency Contact Name_____Relationship_____

Phone Numbers: Home_____ Work_____ Cell _____

Authorization to release treatment and information:

I authorize any examination, including X-ray, laboratory tests, application of splints or casts, and administrations of injections and/or aspirations during the course of the diagnosis and treatment. I give my consent to the treating physician to perform the necessary medical and surgical treatment of my care.

I hereby authorize the release of all medical information to insurance carriers concerning my treatment and assign to the physicians all payment for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

_____ _____/_____/_____

Signature of patient / parent / guardian Month Day Year

Foot and Ankle CENTER
a division of PACE FOOT AND ANKLE CENTERS

Medical History

931 E. Haverford Road, 3rd Floor, Bryn Mawr, PA 19010 • 610.642.5040 • FootAndAnkleCenterOnline.com

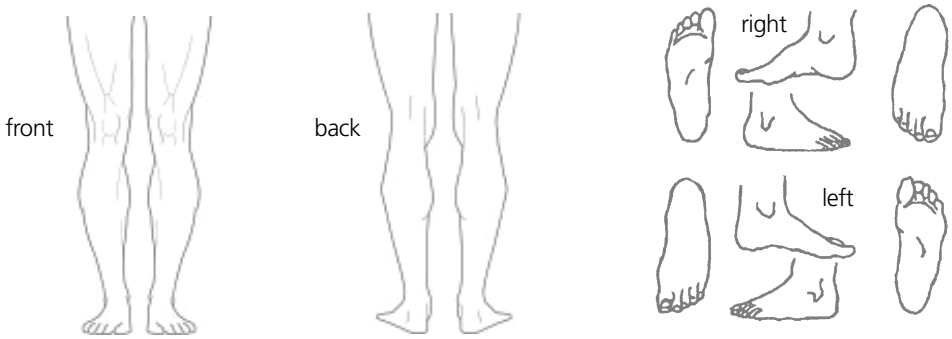
_____/_____/_____
Last Name | First Name | Middle Initial | Date of Birth

Chief Problem / Complaint / Injury: ❑ Foot ❑ Ankle ❑ Leg ❑ Right ❑ Left

Date of Problem / Complaint / Injury or how long have you had this problem_____

Where did the injury occur (if applicable) ❑ Work ❑ Home ❑ Other

Please mark where the problem occurs:



Previous Treatments *(check all that apply):*
❑ Anti-Inflammatories ❑ Insert ❑ Surgery ❑ Physical Therapy ❑ Brace ❑ Injections ❑ Cast / Boot / Immobilization
❑ Other _____

Previous Tests *(check all that apply):* ❑ Bone Scan ❑ CT Scan ❑ MRI ❑ Ultrasound ❑ X-ray

YOUR Medical History *(check all that apply):*

❑ Angina
❑ Heart Murmur
❑ Hypertension
❑ Foot/Leg Swell
❑ Blood Clotting
❑ Ulcer/Stomach
❑ Bleeding Disorder
❑ Diabetes
❑ Arthritis: ❑ Osteo ❑ Rheumatoid ❑ Other_____
❑ Stroke
❑ Vascular Disease
❑ HIV
❑ Bronchitis/Asthma
❑ Hepatitis
❑ Other_____
❑ Anemia
❑ Epilepsy/Seizure
❑ Back Injury
❑ Thyroid Disease
❑ Phlebitis
❑ Heart Disease

FAMILY (parents, grandparents, siblings) Medical History *(check all that apply):*

❑ Angina ❑ Diabetes ❑ Heart Murmur ❑ Anemia ❑ Arthritis
❑ Epilepsy ❑ Hypertension ❑ Stroke ❑ Foot/Leg Swell ❑ Peripheral Vas Dis
❑ Thyroid Disease ❑ Blood Clotting ❑ Phlebitis ❑ Ulcer/Stomach ❑ Bronchitis/Asthma
❑ Heart Disease ❑ Seizures ❑ Other_____

(over...)

Are you currently, or have you recently experienced any of the following SYMPTOMS?

❑ Fever	❑ Headaches	❑ Weight gain	❑ Blood in stool	❑ Jaundice
❑ Chills	❑ Double vision	❑ Weight loss	❑ Blood in vomit	❑ Rash
❑ Night sweats	❑ Ringing in ears	❑ Weakness	❑ Dark black stool	❑ Hives
❑ Tremor	❑ Numbness	❑ Sexual dysfunction	❑ Constipation	❑ Eczema
❑ Nose bleeds	❑ Tingling	❑ Urethral discharge	❑ Diarrhea	❑ Psoriasis
❑ Irregular heartbeat	❑ Dizziness	❑ Painful urination	❑ Indigestion/reflux	❑ Unusual moles
❑ Chest pain	❑ Fainting	❑ Blood in urine	❑ Abdominal pain	❑ Anxiety
❑ Trouble swallowing	❑ Hoarseness	❑ Cough	❑ Swollen legs	❑ Depression
❑ Short of breath	❑ Wheezing	❑ Blood in sputum	❑ Painful joints	❑ Panic

Please explain any item checked or list symptoms not mentioned above.

_____

Please list ALL medications you are currently taking including vitamins, aspirin, etc.

_____

_____

_____

_____

_____

Are you allergic to *(check all that apply)*: ❑ Medications ❑ Adhesive Tapes ❑ Metals ❑ Foods

If so, please list all allergies: *(what happens when allergic?)*

_____

_____

_____

_____

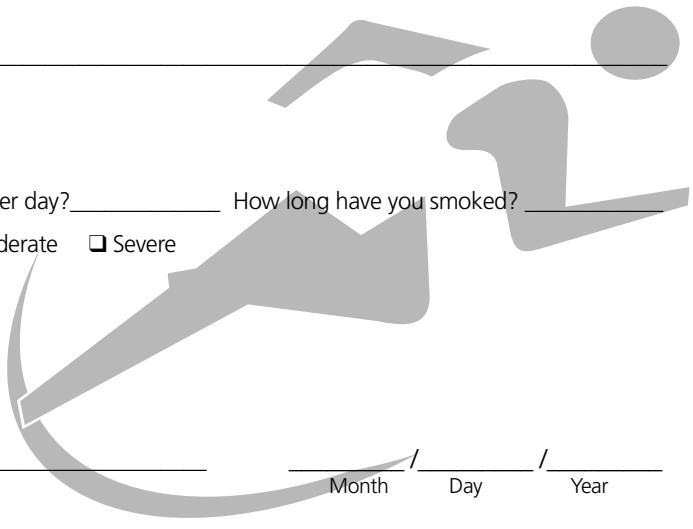
Past Surgical History

Do you smoke? ❑ Yes ❑ No If yes, how many packs per day?_____ How long have you smoked? _____

Do you drink alcohol? ❑ Yes ❑ No If yes: ❑ Mild ❑ Moderate ❑ Severe

Do you use drugs? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No ❑ Not sure



_____ _____/_____/_____

Signature of patient / parent / guardian Month Day Year

Foot and Ankle CENTER
a division of PACE FOOT AND ANKLE CENTERS

Financial Policy

931 E. Haverford Road, 3rd Floor, Bryn Mawr, PA 19010 • 610.642.5040 • FootAndAnkleCenterOnline.com

Welcome and thank you for choosing The Foot and Ankle Center for your medical care.

We are committed to providing you with the highest quality medical care possible in a cost effective manner. Our professional fees have been determined through careful consideration, in addition to being reasonable and customary within our geographical area. We are pleased to discuss with you any questions you may have concerning a bill.

Payment **in full** is due at the time services are rendered. As a courtesy to our patients we accept cash, personal checks, and Amex, Visa and MasterCard.

We also provide our patients with the ability to pay for their accounts online at: **www.footandanklecenteronline.com** or by phone at **610.642.5040**

Office Hours:

Monday:	8:00am to 4:30pm
Tuesday:	8:00am to 7:00pm
Wednesday:	8:00am to 7:00pm
Thursday:	8:00am to 7:00pm
Friday:	8:00am to 4:30pm
Saturday:	8:00am to 12:00pm

Things to bring with you to each appointment:

- Health Insurance Card(s)
- Drivers License
- Method of Payment
- Any X-rays, CTs, MRIs related to reason for visit

In order to achieve our goal of providing you with the best care possible, we need your assistance and understanding of our financial policy:

Appointments:

- Please arrive for your appointment 15 minutes early.
- It is your responsibility to verify that we are currently under contract with your insurance plan and that you have obtained all of the necessary referrals **before** your scheduled appointment. Please call our office for the necessary Provider ID's needed. Failure to do so may result in your appointment being rescheduled.
- Please inform the receptionist of any demographic changes (phone number, address, insurance information, etc.) Failure to notify us immediately of changes in demographic information, financial status and/or insurance coverage may result in you being responsible for any services not covered by your insurance carrier.

Missed or Cancelled Appointments:

- If you are more than 15 minutes late for an appointment, it may result in your appointment being rescheduled, we ask that you please notify us as soon as you can.

" In Network" vs. "Out of Network" Insurance:

- Your insurance coverage and benefits are a contract between you and your insurance company and therefore all disputes must be handled between you and your insurance company.
- While we make every effort to assist you with your insurance questions and submissions, you must understand that is it YOUR responsibility to verify your insurance coverage and to understand the extent of that coverage.
- Insurance companies are obligated to YOU, THE INSURED, and not to our office. It is often difficult or impossible for us to get information regarding your insurance.
- If you have insurance coverage under a plan with which we do not have a contract, you will be treated as a self pay patient.
- **Medicare Patients - Please make sure you have a full understanding of your benefits and what might be your responsibility if not covered by your insurance plan.**

Payment is Due at the time services are rendered:

- Co-pays and all non-covered items and charges are the insured/patients financial responsibility and are due during the check-out process.
- Any outstanding balance may incur a monthly statement processing fee, in addition to the initial balance.
- There will be a fee of $30 for any returned checks to our office.

Self Pay Patients:

- We try to be very understanding for our cash paying patients. All fees will be due at the time services are rendered. Our staff will be able to give you an estimate of your appointment fees, but please keep in mind it is often impossible for us to quote what will be done at your appointment.

(over...)

Additional Paperwork:

- Any paperwork needed to be filled out by our Physicians or staff will result in either a $5, $10, or $15 charge, depending on the length of the paperwork.
- A 48-hour notice is REQUIRED for all paperwork.

Auto Accidents/Workers' Compensation:

- Motor Vehicle Accidents (MVAs) will be filed to your auto insurance as a courtesy to you. Failure to provide us with ALL info needed to file may result in you being responsible for paying for all charges incurred. *(i.e. Insurance carrier name, adjustors name and phone number, medical claims billing address, claim number.)*
- Our office will send appropriate workers' compensation claim forms for services rendered on your behalf as a courtesy. If a claim is denied, we will expect payment in full from you within 30 days of receipt of your bill.

Lab/Hospital Charges:

- Any services provided by a lab or hospital is a contract between you and that lab or hospital. Any dispute with that lab or hospital should be handled with that lab or hospital and is not the responsibility of our practice.
- It is your responsibility to know which procedures your insurance will and will not cover at these facilities and to request an explanation of benefits (EOB) from your insurance carrier.

Payment Plans:

- Our office will be happy to work with you in order to pay any balance due to our practice.
- Please contact our billing department to work out a payment plan with our practice.
- Please mail all payments to our office:
  The Foot and Ankle Center
  931 E. Haverford Road, 3rd Floor
  Bryn Mawr, PA 19010
  Or make payments online: www.footandanklecenteronline.com
  Or by phone: 610.642.5040

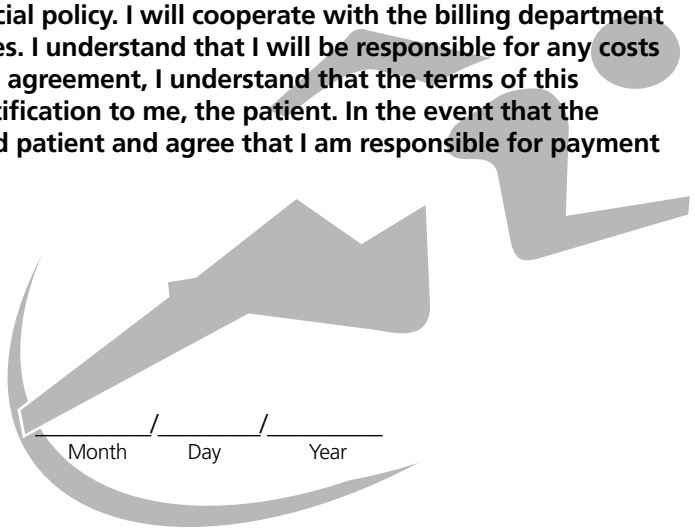
Refunds:

- Patient refunds will not be processed until all active or past due charges are paid in full.
- Please allow 2-3 weeks for refunds to be processed and mailed.

Patient Consent:

By signing this document, I _____, have fully read and understand the financial policy of the Foot and Ankle Center. I hereby consent to allow the Foot and Ankle Center to reach me if needed concerning any billing questions or concerns.

I understand and consent to the Foot and Ankle Center's financial policy. I will cooperate with the billing department of the Foot and Ankle Center to ensure payment for my services. I understand that I will be responsible for any costs associated with the collection of my account if I default on this agreement, I understand that the terms of this financial policy may be amended at any time without prior notification to me, the patient. In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for payment for all services rendered to the patient herein.



_____
Printed name of patient / mother / father / guardian

_____ _____/_____/_____
Signature of patient / mother / father / guardian Month Day Year

Foot and Ankle CENTER
a division of PACE FOOT AND ANKLE CENTERS

Privacy Practices

931 E. Haverford Road, 3rd Floor, Bryn Mawr, PA 19010 • 610.642.5040 • FootAndAnkleCenterOnline.com

NOTICE OF PRIVACY PRACTICES
Protecting Your Confidential Health Information is Important to Us

NOTICE OF PRIVACY PRACTICES
This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Promise
Dear Patient
This notice is not meant to alarm you. Quite the opposite. It is our desire to communicate to you that we are taking seriously Federal law (HIPAA-Health Insurance Portability And Accountability Act) enacted to protect the confidentiality of your health information. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy?
Very good question! The Federal government legally enforces the importance of the privacy of health information largely for response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures, which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State And Federal law regarding the confidentiality of your health information and keeping with the law we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting health care operations, or otherwise described in this notice.

How your Health Information may be used to provide treatment
We will use your HEALTH INFORMATION within our office to provide you with medical care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between Physicians, Medical Assistants, Radiology Technicians, and business office staff. In addition, we may share your health information with Physicians, Referring Physicians, clinical laboratories, pharmacies or other health personnel providing you treatment.

To Obtain Payment
We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations
Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

To Business Associates
We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES
Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law
We may use or disclose your health information as by any statute, regulation, court order or other mandate enforceable by a court of law.

Abuse or Neglect
We may disclose your health information to the responsible government agency if (a) we reasonably believe that you are a victim of abuse, neglect or domestic violence and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless we determine that informing you would not be in your best interests.

Public Health and National Security
We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement
As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers
We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes
We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

(over...)

Protecting Your Confidential Health Information is Important to Us
Judicial and Administrative Proceedings
We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures
We may use or disclose your health information in a manner, which is incidental to the uses and disclosures described in the Notice.

Health Oversight Activities
We may disclose your heath information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert a Serious Threat to Health or Safety
We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

To The U.S. Department of Health and Human Services (HSS)
We may disclose your heath information to HSS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research
We may use or disclose your health information for research subject to conditions. "Research" means systemic investigation designed to contribute generalized knowledge.

In Connection with Your Death or Organ Donation
We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information
Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization at any time.

PATIENT RIGHTS
You have the following rights related to your health information.

Restrictions
You have the right to request restrictions on the use or disclosure of your health information for treatment, payment or health care operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a health care item or service for which you have paid us out-of-pocket in full.

Confidential Communications
You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information
You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Health Information
You have the right to ask us to update your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information
You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of This Notice
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or e-mail a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice. You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our office at address below:

Attn: Office Manager
Foot and Ankle Center, 931 E. Haverford Road, 3rd Floor, Bryn Mawr, PA 19010

Patient Acknowledgement
Patient Name(s)

_____

_____

Thank you for taking the time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate you signing and returning this policy.

_____
Patient Signature

_____
Date Effective Date

Consent to Receive Appointment Reminders via Phone Calls, Text Message, or E-Mail

Patients in our practice may be contacted via phone call, text messaging, and/or e-mail to remind them of an upcoming appointment.

Our practice does not charge for this service, but **standard text messaging rates may apply depending on your wireless plan.**
Contact your carrier for pricing plans and details.

Consent:

I consent to receive phone calls, text messages, and/or e-mail from the Foot and Ankle Center regarding appointment reminders. I understand that this request to receive phone calls, text messages, and/or e-mail will apply to all future appointment reminders **unless** I request a change in writing.

I authorize the Foot and Ankle Center to call and/or leave voicemails for appointment reminders at this phone number: _____

I authorize the Foot and Ankle Center to send text messages for appointment reminders to this cell phone number: _____

I authorize the Foot and Ankle Center to send e-mail regarding appointment reminders to this e-mail address: _____

Patient Name: _____ **Date**: _____
Patient/Representative's Signature: _____

To opt out:

I request to opt out of receiving e-mails, phone calls, and/or text messages from the Foot and Ankle Center regarding appointment reminders.

Patient Name: _____ **Date**: _____
Patient/Representative's Signature: _____