Blair Foot and Ankle, LLC
Payment Policy

Payment is due at the time of service which includes:

- Co-pays
- Co-insurances
- Deductibles
- Prior Patient Balances

The office of Blair Foot and Ankle policy required a credit card to secure payments for any unknown balances that your insurance company considers patients responsibility. Nothing additional will be charged to your account today.

After the office of Blair Foot and Ankle receives an Explanation of Benefits (EOB) from your insurance company, you are authorizing the office to charge your credit/debit card for any balance owed, in lieu of sending a bill.

Note: This office utilizes a secure payment system. A signature is required giving authorization for payment. ***Please provide an email address so that we may notify you of any payment transaction. Please DO NOT put your debit/credit card number on this form.***

IF YOU PREFER NOT TO PUT A CREDIT/DEBIT CARD ON FILE, A $200.00 DEPOSIT IS REQUIRED

SELF PAY PATIENTS
Payment is due in full at time of service
Thank you

_____ Debit/Credit Card Deposit

E-mail address

_____

Patients signature/Guarantor's signature Date

- I authorize the office of Blair Foot and Ankle to keep my signature on file and to charge my credit/debit card for any balance of charges related to all transactions at the office.

HIPPA Authorization

I _____give the office of Blair Foot and Ankle, LLC. Permission to communicate medical information to the following persons:

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

Signature: _____

Date:_____

Please Print

Date: _____Home Phone: _____Cell Phone: _____

Patient Name: _____
Last Name First Name Initial Social Security Number

Responsible Party (if a minor): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Sex: ف M ف F Age _____ Birthdate _____ ف Single ف Married ف Widowed ف Divorced

Patient Employed By: _____

If Minor, Responsible Party Employed By: _____

Business Address: _____

Occupation: _____ Business Phone: _____

Spouse (or responsible party) Employed By: _____

Purpose of Visit (Specify) _____

Who is responsible for this account? _____ SS#_____
(Other than Insurance) (NAME)

Medical Insurance Information:

Name of Primary Insurer: _____

Contract # _____ Group# _____ **Subscriber _____**
DOB: _____/_____/_____

Name of Secondary Insurer (if any) _____

Contract# _____ Group# _____ Subscriber _____

ف Medicare ف Medicare Railroad ID# _____

***PAYMENT IS DUE AT TIME OF SERVICE**
***PATIENT RESPONSIBILITY IS DUE UPON RECEIVING YOUR EXPLANATION OF BENEFITS FROM YOUR INSURANCE COMPANY**
***ALL CO-PAYS ARE DUE AT TIME OF SERVICE.**
***ALL PURCHASED PRODUCTS ARE DUE PAYABLE AT TIME OF VISIT**

I have read and fully understand the above

_____ _____
Patient/guardian of patient date

In case of emergency, who should be notified? _____ Phone: _____

How did you learn of our practice? _____

Blair Foot and Ankle, LLC
1798 Plank Road, Suite 201
Duncansville, PA 16635

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to the practice of Blair Foot and Ankle, LLC. All medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured/Guardian Date

FINANCIAL RESPONSIBILTY

I fully understand that this office will bill my primary insurance and if failure to pay results for any reason, I will be responsible for the account. I have been made aware that my primary insurance will be billed on my behalf and it is my responsibility to forward the claim to my secondary insurance. I understand that any **non-covered benefit** that I receive, I am financially responsible for. I understand that this office **DOES NOT participate** with government assisted medical insurance programs i.e, **Medicaid**.

_____ _____

Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to the practice of Blair Foot and Ankle, LLC for any services furnished me by the physicians of that practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

I understand this office transmits their bills electronically. If arrangements have not been made for Medicare to forward the claim to my secondary insurance, I will be responsible to submit my claim to my secondary insurance.

_____ _____

Beneficiary Signature Date

PERMISSION TO EVALUATE AND TREAT

I/guardian give permission to be evaluated and treated by Blair Foot and Ankle, LLC.

_____ _____

Patient/Guardian Signature Date

LATE ARRIVAL POLICY

As a courtesy to others, we reserve the right to reschedule your appointment if you are more than **15 minutes late**.

APPOINTMENT CANCELLATION/NO SHOW POLICY

Effective immediately January 1st, 2022 any established patient who fails to show or cancels/ reschedules an appointment and has not contacted our office with at least a **24 hour notice** will be considered a **No Show** and charged a **$25.00 fee**.

Any established patient who fails to show or cancels/reschedules an appointment with no **24 hour notice** a second time will be charged a **$50.00 fee**.

If a third instance occurs, the patient may be liable to dismissal from the practice, Blair Foot and Ankle, LLC.

***The fee is charged to the patient, not the insurance. The fee will be charged on the day of the no show or hasty cancellation.**

Our office provides courtesy call reminders for all patient appointments. These calls will be received by the patient a full two days before their scheduled appointment. This is to give notice and significant time to our patients in the case that they need to cancel/reschedule. Please be sure to listen to the message carefully and to select the proper response. Improper response to the message may in turn cancel an appointment by accident.

PATIENT MEDICAL, FAMILY, SURGERY HISTORY AND REVIEW OF SYSTEMS WORKSHEET

DATE: _____ PATIENT: _____ DOB: _____

			Comments/Treatment
Arthritis	Y__	N__	_____
Bleeding tendency (bruise easily)	Y__	N__	_____
Cancer/Leukemia	Y__	N__	site:_____
Diabetes Type I or Type II (diet, pill, insulin)	Y__	N__	tx:_____
Circulation (cold feet/hands, color changes, pain in legs)	Y__	N__	_____
Eye Problems	Y__	N__	_____
Epilepsy/Seizures	Y__	N__	_____
Thyroid/Endocrine Disease	Y__	N__	_____
Heart: (Angina, Murmur, MI) (chest pain, heart attack, stent)	Y__	N__	date:_____
Rheumatic Heart/Valve Disease (do you Need antibiotics before treatment?)	Y__	N__	_____
High Blood Pressure	Y__	N__	_____
Stroke (CVA)	Y__	N__	date:_____
Headaches	Y__	N__	_____
Hernia/Gastric Ulcer (heartburn)	Y__	N__	_____
Hepatitis/Jaundice	Y__	N__	_____
Gout	Y__	N__	_____
Kidney Disease/Stones	Y__	N__	_____
Lung: (Breathing Problems: TB, asthma)	Y__	N__	_____
Mental Illness (nervous breakdown, anxiety)	Y__	N__	_____
Pregnancy Status:			
Are you pregnant?	Y__	N__	_____
Planning pregnancy?	Y__	N__	_____
Prostate Problems	Y__	N__	_____
Anesthesia Problems (include family)	Y__	N__	_____
Back Injury	Y__	N__	dates:_____

Other(e.g. recent exposure to communicable disease)_____
_____

Family History

Cancer	Y__	N__	High Blood Pressure	Y__	N__
Diabetes	Y__	N__	Heart Disease	Y__	N__
Stroke	Y__	N__	Foot Problems	Y__	N__

Other _____

Medical Doctor:_____
Medical Doctor's address _____ Phone #: _____
Date of last exam or visit with Medical Doctor: _____

Height _____
Weight _____

Patient name: _____

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Social History
Occupation:_____
Home life (married, children, etc.)_____

Alcohol (how much?)_____
Caffeine (how much?)_____
Do you use tobacco now? Y__ N__
When did you quit?:_____
Packs per day_____for_____year(s)_____
Do you use smokeless tobacco? Y__ N__
Recreational drugs? Y__ N__

Allergies:
Latex: Y__ N__
Food: Y__ N__ _____
Environmental: Y__ N__ _____
Medication ***Allergies***:
Med:_____ Reaction:_____
Med:_____ Reaction:_____
Med:_____ Reaction:_____

Surgical History

Foot Surgery	Y__	N__	Heart Surgery	Y__	N__
Tonsils	Y__	N__	Dental Surgery	Y__	N__
Appendix	Y__	N__	Joint Surgery	Y__	N__
Gall Bladder	Y__	N__	Fracture Repair	Y__	N__
Back Surgery	Y__	N__	Hernia Repair	Y__	N__
Transfusion	Y__	N__	C-Section	Y__	N__
Anesthesia Problems	Y__	N__	Other:_____		

Special Concerns
Do you use any of the following to ambulate?
Walker / Cane / Brace / Crutches / Wheelchair / Prosthesis / Special Shoe
Do you have stairs at home? Y__ N__
Do you live by yourself? Y__ N__
Can you touch your feet in order to care for them? Y__ N__
Is there a barrier to understanding and following treatment directions? Y__ N__
Is this related to a:
Motor vehicle accident? Y__ N__
Workman's Comp Claim? Y__ N__
Malpractice Suit? Y__ N__

Do you take any herbs or diet supplements? Y__ N__

Foot/Ankle Care History
Have you been treated for any other foot/ankle problems? Y__ N__
If so, when?_____where?_____
what treatment?_____
Have you had foot surgery? Y__ N__
Do you wear arch supports? Y__ N__

Patient name: _____

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REVIEW OF SYSTEMS Under each category, circle any symptom you experience or circle the word none.

GENERAL	EYES	EAR, NOSE, THROAT	HEART	RESPIRATORY	URINARY
None	None	None	None	None	None
Fever	Blurry vision	Hearing loss	Chest pain	Cough	Frequency
Chills	Double vision	Pain	Palpitations	Shortness of breath	Hesitancy
Weight loss/gain	Flashes	Dry mouth	Swelling	Wheezing	Discharge
Loss of appetite	Pain	Nosebleeds			Pain

MUSCULO/ SKELETAL	SKIN	NEUROLOGIC	PSHYC.	ENDOCRINE	HEMATOLOGIC
None	None	None	None	None	None
Joint pain	Rash	Numbness	Depression	Heat cold intolerance	Anemia
Swelling	Itching	Tingling	Anxiety	Increased thirst/ Or urination	Bruising
Stiffness	Skin changes	Weakness			Bleeding
Arthritis	Nodules	Headaches			Swollen glands
Back pain	Open wounds	Seizures			
		Paralysis			
		Loss of balance			

INFECTIONS				
None	Fever	Hepatitis	Bone infection	HIV/AIDS
STD	Tick bites	Transfusion	History of MRSA	Tuberculosis

This patient medical, family, surgical history and review of systems worksheet was completed/reviewed/updated by the following on date noted.

_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____

Patient name: _____

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MEDICATION LIST

PATIENT NAME: _____

PHARMACY: _____

PHARMACY PHONE#: _____

Are you currently taking any medications (including herbal supplements or vitamins)?
Yes _____ No _____ If yes, please list:

DATE						
MEDICATION	DOSE	DOSE	DOSE	DOSE	DOSE	DOSE

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