

**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

E-mail address

Debit/Credit Card Deposit

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

_____ Name	_____ Relationship	_____ Phone Number
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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: M F Age _____ Birthdate _____ Single Married Widowed 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 _____

Medicare 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? _____

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 RESPONSIBILITY

I fully understand that this office will bill my primary insurance and if failure to pay results for any reason, I will be financially 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 notify my primary insurance of any secondary insurances that I hold. Once the coordination of benefits has been established, any/all claims may be sent to my secondary insurance. I understand that any **non-covered benefit** that I receive, I am financially responsible for.

Signature of Insured/Guardian

Date

MEDICARE/MEDICAID AUTHORIZATION

I request that payment of authorized Medicare or Medicaid 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 or Medicaid assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare or Medicaid 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 or Medicaid carrier.

I understand this office transmits their bills electronically. If arrangements have not been made for Medicare or Medicaid 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: _____

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:	_____
Neurological Disorder	Y__	N__			_____
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 _____

Date of last exam or visit with Medical Doctor: _____

Phone #: _____

Height _____

Weight _____

Patient name: _____

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

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__

Tonsils Y__ N__

Appendix Y__ N__

Gall Bladder Y__ N__

Back Surgery Y__ N__

Transfusion Y__ N__

Anesthesia Problems Y__ N__

Heart Surgery Y__ N__

Dental Surgery Y__ N__

Joint Surgery Y__ N__

Fracture Repair Y__ N__

Hernia Repair Y__ N__

C-Section 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: _____

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: _____

