Traction Podiatry Group – Craig Foster, DPM

3570 South Val Vista Drive, Suite 104, Gilbert, AZ 85297

First name *Last name*

Email

Mailing Address

City **State** **Zip**

Phone **Date of Birth**

Marital Status **Sex**

Height **Weight** **Shoe size**

Race **Ethnicity**

**This information is requested due to Healthcare Reform laws dictated by Congress.*

Preferred language

Are you pregnant **Are you nursing**

Have you completed an Advance Directive (living will)?

Primary Care Physician

Primary Care Physician Address

Physician Phone Number **Date Last Seen**

Pharmacy **Pharmacy Phone**

Who referred you to our office?

Primary Reason for Visit

Duration of Condition

What helps / makes it worse?

Is it limiting your desire activity level?

Secondary concerns (if there are any)

Please list any drug allergies

List Medications You Take

Medical History

Other history

If you have cancer, please list type and treatment

What surgeries have you had?

Is your problem related to a Workman's Comp injury or an auto/other accident *No*

Social History

Do you drink alcohol **How often**

Do you smoke, vape or use chewing tobacco

Do you have/have had a substance abuse problem

Family History

Diabetes **Stroke**

Cancer **Arthritis**

Heart Attack **HTN**

Insurance Information

Subscribers name _____ **Subscribers D.O.B.** _____

Patient's Relation to the Subscriber _____ **HMO** _____

Primary Insurance _____

Policy Number _____ **Policy Holder Date of Birth** _____

Policy Holder Name _____

Secondary Insurance _____

Secondary Policy Number _____

Occupation _____

Employer _____

Employer Address _____

City _____ **State** _____ **Zip** _____

Employer Phone Number _____

Emergency Contact

First Name _____ **Last Name** _____

Relationship to Patient _____ **Phone** _____

Responsible Party (if minor patient)

First Name _____ **Last Name** _____

Relationship to Patient _____ **Date of Birth** _____

Consent for Treatment and Acknowledgement of Policies

For any insurance plan that requires authorization from a primary care physician (e.g. HMO, PPO, etc.) it is your responsibility (as patient or guardian) to be sure that this office receives all necessary referrals or authorizations PRIOR to treatment. Professional services are rendered and billed directly to your insurance carrier; however you, the patient/guardian, are directly responsible for services rendered by the doctor. A health insurance policy is a contract between you (the patient or subscriber) and your insurance carrier. You MUST notify this Office of any changes to your insurance policy including policy termination, changes in co-payments or a new insurance policy. If for any reason the insurance carrier denies charges, payments for any services rendered will become the responsibility of the patient/guardian.

I Agree (*) _____

All office visit charges and co-pays are due at the time services are rendered. It is the patient who is responsible for any and all financial aspects of services rendered. There will be a charge for returned checks, missed appointments without 24 hours notice and completion of any forms. I agree to pay for all deductibles, co-pays, non-covered services and any portion of covered services not paid in full by my insurance plan and understand that such payments are due at the time of service or immediately upon presentation of the bill. I hereby name Traction Podiatry Group (TPC) as my assignee. I instruct my health care benefits plan administrator, i.e. PLAN to pay TPC directly for all professional and medical services provided by TPC through the means of electronic funds transfer(s) (EFT) or by check(s) made payable to and mailed to TPC. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS.

I Agree (*) _____

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. I also give permission for photographs of my feet to be taken that are to be kept as part of my medical record only. They will not be published as part of medical research or disbursed in any way without my permission.

I Agree (*)

I acknowledge that I was provided a copy of the **Notice of Privacy Practices for Traction Podiatry Group** and I have read (or had the opportunity to read if I so choose) and understood the Notice.

I Agree (*)

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 responsible 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.

I Agree (*)

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.

I Agree (*)

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.

I Agree (*)

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.

I Agree (*)

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.

I Agree (*)

SURGERY CANCELLATION: Failure to provide 5 business-days notice before surgery will incur a $500 fee.

I Agree (*)

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.

I Agree (*)

FMLA/DISABILITY/MEDICAL RECORDS: There is a $25 charge for having the doctor complete these forms. Requested forms will be completed within 72 hours of diagnosis and care plan. There is a $15 fee to obtain a copy of your medical records. I Agree (*)

I Agree (*)

I have read and understand these financial policies.

PAYMENT RESPONSIBILITIES

We are pleased to welcome you to our office. New Patients are always appreciated. Our practice has grown as a result of its excellent relationship with our referring doctors and patients. As our patient, please feel free, at any time, to express any concerns or to ask any questions that you may have for the doctor or our staff. In order to assist you in making payment(s) for your podiatric treatment, the following options are listed. Please read them carefully and feel free to discuss them with us.

If you DO NOT have insurance: Payment is due, in full, at the time treatment is provided.

*For your convenience, we accept all major credit/debit cards and cash. We accept personal checks for payments under $50.00.

If you have Insurance: The percentage of coverage by your insurance company may be based on your insurance company's own reduced fee schedule for medical services and may be less than actual charges resulting in lower coverage for you. Traction Podiatry Group has no control over this situation. *Lower payment is a direct result of the plan selected by you or your employer.* **Please be advised that we cannot waive co-payment. We are required by law to collect co-payment.**

Commercial Insurance: We will submit your claim to your insurance carrier for you. You are responsible for any deductible or co-payment not covered by your insurance. Once our office has received payment from the insurance company, you will be billed, with 30 day terms, for any amount still owed. You may choose to keep a credit card on file for those balances left to you by your insurance company.

Medicare: This office accepts Medicare assignment. Medicare patients are fully responsible, however, for the initial yearly deductible and the 20% co-insurance. Federal law requires that physicians collect this amount. If you have a secondary insurance to cover the 20%, we will submit the balance to that insurance for payment and you will only be responsible for the yearly deductible.

Signature *Date*