Steven D. Gross, DPM Thomas B. Arnold, DPM Adrienne M. O'Neill, DPM Dustin M. Fox, DPM

STARK COUNTY FOOT & ANKLE CLINIC

Patient Name: _____
(First) (MI) (Last)

Address: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Date of Birth: _____ Social Security# *(required)*: _____ Marital Status: S M Sep W D

Employer: _____ Occupation: _____

Spouse/Partner's Name: _____ Work Phone: _____

Emergency Contact: _____ **Phone:** _____

Relation to Patient: _____

Primary Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Insurance Information

Primary Insurance: _____ **Effective Date:** _____

Address: _____ Phone Number: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber's Social Security #: _____ Relationship to Patient: _____

Policy Number: _____ Group Number: _____ Copay: _____

Secondary Insurance: _____ **Effective Date:** _____

Address: _____ Phone Number: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber's Social Security #: _____ Relationship to Patient: _____

Policy Number: _____ Group Number: _____ Copay: _____

I authorize my Insurance Company(s) to send payment to *Stark County Foot and Ankle Clinic* on my behalf. I understand that I am financially responsible for all co-payments, co-Insurance, deductible, and non-covered services.

Signature of Patient/Guardian: _____ **Date:** _____

PODIATRIC HISTORY

/hy are you here today? _____
ave you ever been to a Podiatrist before?___yes ___no If yes, who?_____Last visit?_____
there a family history of Diabetes? ____yes ____no
our Occupation: _____Athletic activities you participate in: _____
urrent Every Day Smoker: How Long_____ How many packs per day? _____
urrent Occasional Smoker: How Long_____ How much? _____
ormer Smoker: Recently Quit _____ How long ago? _____ How much per day? _____
ever a Smoker _____
lease check which foot problems you now have or have had in the past:
)Ankle Pain ( )Athlete's Foot ( )Bunions ( )Corns & Callous ( )Cramps or Numbness (feet or legs)
)Flat Feet ( )Heel Pain ( )Ingrown Toenails ( )Plantar's Wart ( )Swelling in ankles/feet ( )Tired Feet

MEDICAL HISTORY

lease check if you have any of the following:
)AIDS/HIV ( )Allergies to Anesthesia ( )Allergies to Medicine or Drugs ( )Anemia ( )Arthritis ( )Artificial Heart
alves or Joints ( )Asthma ( )Back Problems ( )Bleeding Disorders ( )Cancer ( )Chemical Dependency
)Chest Pain ( )Chronic Diarrhea ( )Circulatory Problems ( )Diabetes ( )Dementia ( )Epilepsy( )Ear Problems
)Eye Problems ( )Fainting ( )Foot or Leg Cramps ( )Gout ( )Headaches ( )Heart Disease ( )Hemophilia
)Hepatitis or Jaundice ( )High Blood Pressure ( )Kidney Problems ( )Liver Disease ( )Low Blood Pressure
)Nervous Problems ( )Phlebitis ( )Psychiatric Care ( )Radiation Treatment ( )Rash ( )Respiratory Disease
)Rheumatic Fever ( )Shortness of Breath ( )Sinus Problems ( )Special Diet ( )Swelling in Ankles/Feet
)Stroke ( )Swollen Neck Glands ( )Tired Feet ( )Tuberculosis ( )Ulcers ( )Varicose Veins ( )Venereal Disease
)Weight Loss – Unexplained
urgeries you have had: _____
_____
lospitalizations other than the above surgeries: _____
'amily Physician: _____ Last Visit: _____
lave you been under the care of any other physicians during the last 2 years? _____Yes _____No
f yes, please explain: _____

MEDICATIONS

'rescriptions, include over the counter and vitamins: _____
_____
_____
)o you take Oral Contraceptives? _____Yes _____No
'harmacy Name: _____ Phone Number: _____

ALLERGIES

)Adhesive/Tape ( )Anticoagulant Therapy ( )Aspirin ( )Codeine ( )Demerol ( )Iodine ( )Local Anesthetics
)Novacaine ( )Penicillin ( )Seafoods ( )Sulfa ( )Other _____

CONSENT

certify the above information is true to the best of my knowledge. I give permission to the doctors to administer ınd perform such procedures as may be deemed necessary in the diagnosis and treatment of my feet.

'atient's Signature: _____ Date: _____

HIPPA RELEASE FORM

lame: _____ **Date of Birth:** _____

Release of Information:

( ) I authorize the release of information including the diagnosis, record, examination ordered to me and claims information. The information may be release to:

( )Spouse/Partner _____
( )Children _____
( )Other _____
( ) DO NOT RELEASE TO ANYONE

This release will remain in effect until terminated by me in writing.

MESSAGES:

Please call: ( )My home _____
( )My work _____
( )My cell _____
( )Other _____

If unable to reach me:

( ) you may leave a detailed message.
( ) leave a message asking me to return your call.
( ) _____.

Best time to reach me is _____.

Signed: _____ **Date:** _____

Employee: _____ **Date:** _____

Stark County Foot & Ankle
Financial Policy

Steven D. Gross DPM
FACFAS

Thomas B Arnold DPM
FACFAS

Dustin M Fox DPM
AACFAS

OFFICE FINANCIAL POLICY

Stark County Foot & Ankle Clinic participates with many health insurance carriers. We file your claim as a courtesy to you, but you must provide our office with a copy of your current card at each and every visit. If you can't provide your current information, you may be expected to pay for your visit. **The patient, or responsible party, is ultimately responsible for any charges incurred in our office whether you think your insurance should pay for those charges or not.**

Our staff has made efforts to contact your insurance carrier prior to your visit and obtained your health insurance benefit information, such as dates of eligibility, benefits, co-pay, co-insurance and deductibles. Every effort is made to obtain the most current information that your insurance carrier can provide us. **We can't guarantee the accuracy of the information given to us by your insurance carrier. We recommend you contact your insurance carrier directly if you have any questions about your policy. A quote from your insurance carrier is NOT a guarantee of payment.**

Your insurance is a contract between you and your insurance company. It is *your* responsibility to contact your insurance company to confirm network status of the physician prior to your visit. Not all services are a covered benefit. It is *your* responsibility to check with your insurance company prior to your visit regarding what services will or will not be covered.

PLEASE BRING YOUR INSURANCE CARD AND A PHOTO ID TO EVERY APPOINTMENT.

Forms of payment accepted: We accept Cash, check, money orders, Visa, MasterCard and Discover. Please Note: Our office charges a $37.00 fee for all checks returned by the bank for non-sufficient funds.

REFERRALS: are the patient's responsibilities to obtain. If a referral is required by your insurance carrier and hasn't been received, you will be asked to reschedule your appointment.

CO-PAYS: are to be paid at the time of service PRIOR to being seen by the physician. If you are unable to pay your co-pay you may be asked to reschedule your appointment. If for some reason we do not collect your co-pay at the time of the visit we will bill you for it. The exception would be if you require emergency care.

MEDICAID: Medicaid patients MUST present/provide a CURRENT medical card before each visit. Without proof of current coverage, we may have to reschedule your appointment.

NO INSURANCE/SELF PAYS: If you are not covered under a health insurance plan, full payment is required at the time of service. We will collect $150.00 dollars prior to you seeing the physician. We will bill you for any services that we provide to you that exceed $150.00.

ARRIVING LATE: If you are not checked in at the front desk 10 minutes before your scheduled appointment time, we reserve the right to re-schedule your appointment.

NEW PATIENTS: New Patients are to arrive at the office 30 minutes in advance of their appointment time to fill out necessary paperwork. **If all of your paperwork is not completed BY YOUR APPOINTMENT TIME, we reserve the right to reschedule you.**

WORKERS COMPENSATION: You will need to provide the office with your date of injury, claim number, allowed diagnosis, and the name, address and phone number of the company handling the claim. **If your claim is in pending or disallowed status or inactive, your services will be billed through any private health insurance you have thus making you responsible for any co-pay, co-insurance or unmet deductible amounts.**

WE REQUIRE A DOWN PAYMENT: toward your **co-insurance** and **deductible** amount at the time of service, prior to any surgery or procedure, that will be applied toward your balance. Keep in mind that this is a portion of your financial responsibility and does not represent the final monetary balance for your treatment.

CUSTOM ORTHOTICS AND DME: often have different insurance **benefits** than office visits and procedures. In order to cover our costs on **Custom Molded Orthotics we require a $100.00 down payment at the time of molding. Cam Walkers we require $100.00 down payment and AFO's we require $75.00 down payment.** This is the bare minimum to cover the costs. If your insurance ends up paying the full amount we will refund the down payment to you in a timely fashion. Please note there are no refunds on deposits for orthotics or DME.

BILLING: You will receive a monthly billing statement from our billing office at the Aultman MSO. If you believe there is an error with your bill please contact our billing service at 330-479-8705. Full payment is due within 30 days of the statement due date. If needed payment arrangements can made through the Aultman MSO by calling 330-479-8705. **Accounts that become delinquent will be referred to a collection agency. If your account has been sent to collections we will not be able to schedule appointments for you until the matter is resolved. Also, if you have been sent to collections you may be dismissed as a patient of this practice.**

NON SUFFIECIENT FUNDS/CHECKS: a $37.00 non-sufficient funds fee will be assessed per check returned to Stark County Foot & Ankle.

COPIES OF MEDICAL RECORDS: A signed authorization is required for release of your medical records. It may take up to 7 days to obtain your file copies.

DISABILITY FORMS/FMLA PAPERS: A $20 fee must be paid PRIOR to physician completion. It may take 1 week to complete.

MISSED & LATE APPOINTMENTS: At least a 24 hour notice must be given for appointment cancelations. Exceptions are emergencies and special circumstances. Without notice, a $35.00 may be charged/ attached to your account for cancelations and/or missed appointments. A patient may be dismissed from our practice at the Practice Manger/Physicians discretion for 2 or more No-Shows and/or for repeated cancelations.

PATIENT ACKNOWLEGEMENT

I have read the above policy and understand my financial obligations.

X_____ _____

Signature of patient or responsible party **Date**