Anderson Foot Clinic Patient Information Form

Patient Information:

Name: _____ Generation: _____ Gender: M / F
(First) (M.I.) (Last) Jr / Sr.

Social Security Number: _____ Date of Birth: ____/____/____ Age: _____
MM DD YYYY

Mailing Address: _____
(Street) (City) (State) (Zip)

Physical Address: _____
(Street) (City) (State) (Zip)

Telephone Numbers: _____
(Primary) (Secondary) (Work)

Employer: _____ Full Time: Yes / No / Retired
(Name) (Address) (Phone)

Primary Care Physician: _____
(Name) (City) (State) (Phone)

Do you see an Endocrinologist: ___ No ___ Yes _____
(Name) (City) (Phone)

Emergency contact: _____
(Name) (Relationship to Patient) (Phone)

Spouse, Parent, or Legal Guardian: _____
(☐ Please check if same as above) (Name) (Relationship to Patient)

Address: _____ Phone: _____
(☐ please check if same as above)

Spouse/ Parent Employer: _____ Phone: _____

Did someone refer you to our office? _____
☐ Friend ☐ Doctor ☐ Nurse/ FNP ☐ Other

How did you hear about us? _____
☐ Online ☐ Radio ☐ Billboard ☐ Newspaper ☐ Other

Circle Answer Below:

Marital Status: Single / Married / Widowed / Divorced / Separated / Partner

Language: English / Spanish / Other _____ **Student**: Not a Student / Part Time / Full Time

Ethnicity: Hispanic / Not Hispanic **Race**: White / Asian / Black / Native American / Other _____

I certify the information that I have provided is correct and to the best of my knowledge:

_____ _____ _____
Signature of Guarantor or Patient/Guardian **Print Name** **Date**

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Insurance Information: Patient Name: _____ D.O.B._____
(Please indicate if None)

Primary Insurance Company: _____

Policyholder: _____
(Name) (Social Security Number) (Date of Birth) (Relationship to Patient)

Second Insurance Company: _____

Policyholder: _____
(Name) (Social Security Number) (Date of Birth) (Relationship to Patient)

Third Insurance Company: _____

Policyholder: _____
(Name) (Social Security Number) (Date of Birth) (Relationship to Patient)

_____**INT** *I/we hereby name the doctor(s) and/or Mid Missouri Foot and Ankle Center, Inc., dba Anderson Foot Clinic, hereafter referred to as *Doctor*, as my/our assignee. I/we instruct my/our health care benefits provider (i.e.; insurance company, HMO, employer, union or government-run health plan), hereafter referred to as the *Plan*, to pay the *Doctor* directly for all professional and medical services provided. Payment should be made by means of electronic funds transfer(s) (EFT) or by check(s) made payable to and mailed directly to the *Doctor*. If my current policy prohibits direct payment to doctors, then I/we hereby instruct and direct the *Plan* to make out all checks payable to me/us and mail the payments to me/us in care of the *Doctor* as given directly above. This is a direct assignment of my/our rights and benefits under this policy.

*I/we grant the *Doctor* a limited Power of Attorney to sign my/our name(s) in order to deposit and negotiate any payment received from the *Plan* and apply funds received toward my/our outstanding balance. These payments will not exceed my/our indebtedness to the above designated *Doctor*. I/we agree to promptly pay any remaining balance due on all professional and medical service charges over and above payment(s) from the *Plan*. This assignment shall remain in effect until cancelled in writing by the *Doctor*.

*I/we understand that personal information about me/us will be needed by the *Doctor* and the *Plan* to determine and communicate what services or benefits are covered by the *Plan*, and to submit or process a claim for payment on services rendered and for the *Doctor* to collect all fees owed for those services. Therefore, for the purpose of obtaining payment for services rendered, I/we give the *Doctor*, the *Plan*, the Centers for Medicare & Medicaid Services (CMS), their agents, and/or any other holder of information about me/us, authorization to release and/or exchange medical, billing and collection information.

*A photocopy of this agreement or an electronic facsimile thereof shall be considered as effective and the original.

The Responsible Parties whose signatures appear below agree as follows:

_____**INT** *The Doctor(s), and staff of the Medical Practice named above on this form and hereafter referred to as *Doctor*, are authorized to medically treat the patient named on this form.

**Doctor* is authorized to collect, use and exchange Protected health information (PHI) consisting of the patient's past, present, future medical information and other personal information to treat the patient, communicate with the patient's other health care providers, seek payment, carry our necessary business functions and mandated government reporting requirements. These situations and others, as well as your rights regarding this information are explained in our separate HIPAA Notice of Privacy Practices (NPP) provided to you.

*The Responsible parties agree to pay for all fees and charges for supplies, services and treatment that are incurred by the patient per the terms of this agreement and authorize *Doctor* or agents thereof to make credit investigations, including employment verifications. All charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date. The Responsible Parties remain, jointly and severally, financially responsible for the patient until the *Doctor* receives their notification in writing to the contrary. If the patient is currently a minor, their guarantee is continuing even after the patient reaches the age of majority.

*Not all services and/or fees are covered or paid for by the Responsible Parties' health *Plan*. Therefore, the **Responsible Parties agree to pay for all deductibles, co-payments, non-covered services, and any portions of covered services not paid in full by the Plan and understands that such payments are due at the time of service** or immediately upon presentation of the bill.

*All proceeds from the *Plan* are assigned to *Doctor* where applicable. Payments to *Doctor* may not be withheld, delayed or excused for any reason; including the outcome of medical treatment, liens, lawsuits, any coverage determination by the *Plan* or their processing of claims, the financial insolvency of the *Plan* and/or their contracted intermediaries & medical groups. Responsible Parties are strongly advised to monitor and communicate with the *Plan* to ensure that *Doctor's* claims are paid promptly, since they, as Responsible Parties, are ultimately financially responsible for all amounts owed to *Doctor*.

*If any account balance is not paid in full within 60 days, the entire account balance will be subject to interest, a monthly finance charge and a monthly cost of rebilling/account maintenance charge at *Doctor's* current rate.

*If *Doctor* refers unpaid balances over 60 days old to a collection agency/attorney, Responsible Parties agree to pay the costs of collection and that such fees and costs may be added to the account balance. In a legal action between the parties to this agreement to collect an unpaid balance sue for medical services rendered, the prevailing party shall be entitled to recover reasonable attorney's fees and costs.

*The Responsible parties acknowledge receipt of *Doctor's* Office Policy that includes the terms of this Financial Agreement, Authorization for Treatment & Information Release. This form together with *Doctor's* Office Policy and NPP contain the entire and only agreements between the parties. There are no other agreements, promises, representations or warranties, expressed or implied. The provisions of these agreements shall not be changed or modified except for an instrument in writing signed by the parties hereto. I Acknowledge that I was provided a copy of the Notice Of Privacy Practices and that I have read or (had the opportunity to read) and understand the notice.

_____ _____ _____
Signature of Guarantor or Patient/Guardian **Print Name** **Date**