

Welcome to our Practice

Arp Foot And Ankle Clinic - 801 S College St, Mountain Home, AR 72653 PH: 870-425-7363 Fax 870-425-7387

PATIENT INFORMATION

Please print clearly

TODAY'S DATE _____

Patient First Name _____ MI _____ Last Name _____

Male Female Marital Status: Single Married Widowed Separated

Spouse Name _____ Spouse Date of Birth _____

Patient Home Street Address _____ Apt# _____

PO Mailing address [if applicable] _____

City _____ State _____ Zip _____

Patient Home Ph[] _____ Cell Phone#[] _____

Patient email address [please print clearly] _____

Patient Date of Birth _____ Age _____ Social Security Number _____

Patient Height _____ Weight _____ Shoe Size _____

Patient Occupation _____ Employer Name _____

Employer Address _____ Phone[] _____

Preferred Pharmacy _____

BEST CONTACT INFORMATION

Home Phone Cell phone Work Email

Emergency Contact

Name _____ Phone _____ Relationship _____

PAYMENT AND INSURANCE INFORMATION

- Please present your insurance card and drivers license

upon arrival

Check here if no health insurance

Full Name of Insured _____ Relationship to Patient _____

Insured SS# _____ Insured Date of Birth _____

Insured Employer _____

Employer Address _____

According to my insurance, I am responsible to pay a Co-Pay Amount \$ _____ Deductible Amount \$ _____

Payment today will be made by: Cash Check Visa Master Card

My insurance requires a referral from my PCP before I see a specialist. Yes No

REFERRAL INFORMATION

We appreciate your referrals! Who may we thank for referring you to our office?

Name _____ Address _____

Is this person your: PCP Other Specialist Family Member Friend

Other Referral Sources [check all that apply and please specify names where indicated]:

Internet Search [name] ↓	Phone Book [name] ↓	Our Practice Website	Newspaper Ad [name] ↓	Saw our sign	Insurance Plan or Website [name] ↓	Other [explain] ↓

Please turn over to continue

PODIATRIC HISTORY

Chief foot complaint _____

Affecting the- Right--Left-- Both Feet/Ankles (Circle One)

When did it begin? _____

Did you receive treatment for this condition? Yes No

If so, what type _____

Circle the **degree of pain** you are currently experiencing:
Minimal 1 2 3 4 5 6 7 8 9 10 **Severe**

Have you ever had any of the following **conditions**? Please check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Ankle Instability | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hammertoes |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Heel Pain |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Bone Spurs | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Bunions | <input type="checkbox"/> Limb Length Discrepancy |
| <input type="checkbox"/> Burning Feet | <input type="checkbox"/> Neuromas |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Corns-Callouses | <input type="checkbox"/> Numbness or tingling in foot or toes |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Flat Feet | <input type="checkbox"/> Sprains |
| <input type="checkbox"/> Fracture | <input type="checkbox"/> Sweating/Odor |
| <input type="checkbox"/> Fungal Infections (skin/nail) | <input type="checkbox"/> Tendonitis |
| | <input type="checkbox"/> Ulcers |
| | <input type="checkbox"/> V.D. |
| | <input type="checkbox"/> Warts |

PAST MEDICAL/FAMILY HISTORY

If treated for any of the following- Please all that apply to you & **INDICATE PERSONAL FAMILY HISTORY- M-mother/F-Father**

- | | |
|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Muscle or Joint Pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Peripheral Arterial Disease |
| <input type="checkbox"/> # of Years | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Non-Insulin Dep | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Insulin Dep | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> HeartCondition | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizure Disorders |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> HighBloodPressure | <input type="checkbox"/> Varicose veins |

MEDICATIONS

Are you currently on Blood Thinners? Yes No

You can provide a list of medications or list them below:

Name of Medication	Strength/Mg	Take how often?

Do you currently use: Cigarettes or Tobacco? Yes No

If yes, for how long? _____ How many pks/day? _____

Alcohol use? Yes No Quantity ___ daily ___ weekly ___

SURGERIES

Please list all surgeries	Approximate Date

Name of MD/Family Physician _____

Date of Last Visit _____

ALLERGIES

Have you ever had any adverse side effects or allergies to:

	YES	NO	YES	NO
Adhesive Tape			Metal/Jewelry	
Anticoagulants			Novocain	
Anti-inflammatory Meds			Penicillin Reaction? _____	
Aspirin			Sulfa	
Codeine			Other antibiotics	
Cortisone			Other pain medication	
Iodine			Other	
Latex				

SIGNATURE ON FILE AND PERMISSION TO TREAT

I understand that the information provided on this form is true and correct to the best of my knowledge.

I request that payments of authorized benefits be made on my behalf for any services furnished by **Arp Foot and Ankle Clinic**

I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent. I recognize my financial obligation of any coinsurance, co-pays or deductibles and non-covered services that may be required and I hereby give permission to **Arp Foot and Ankle Clinic** and any qualified staff to evaluate, diagnose and treat my foot and/or ankle condition as may be deemed necessary.

Patient or Authorized Signature _____
 If not patient, state relationship _____ Date _____

Financial Agreement and Payment Policy

Thank you for choosing Arp Foot and Ankle Clinic as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become non refundable if the proper referral is not obtained by then.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. Invoices are sent out every 30 days. If your account is over 60 days past due, you will receive a letter requesting immediate payment. Partial payments will not be accepted unless otherwise approved by our Billing Department. Please be aware that if a balance remains unpaid, we may refer your account to small claims court and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Please help us to serve you better by keeping your regularly scheduled appointment. Repeated missed appointments may lead to a fee or transfer of care from the practice.

9. Forms and Documents. We may charge a reasonable fee to copy your medical record. It is our policy to charge \$5.00 for copies of digital x-rays.

10. Fees. Our billing fees are representative of the usual and customary charges for our area. In addition, there is a \$25.00 fee for all returned checks.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date

Please Turn Over to Continue

Privacy Statement

The Arp Foot and Ankle Clinic will use and disclose your health information for the following purposes: to treat you, to assist other health care providers in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you have any questions, concerns or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices provided to you for the person(s) whom you may contact.

Additional Disclosure Authority

In addition to the allowable disclosures described in the State of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information **including test results** to the persons indicated below.

Please circle your choice(s) below:

Any member of my immediate family	YES	NO
Spouse Only	YES	NO
Voicemail/Answering Machine	YES	NO

Acknowledgement of Receipt of Notice of Privacy Practices:

(Signature represents that I have been offered a copy of the policy)

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understood the Notice.

Signature

Date

Patient Name or Authorized Representative (Print)