

Welcome to our Practice

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

PATIENT INFORMATION Please print clearly

Patient First Name _____ MI _____ Last Name _____
 Race _____ Decline Ethnicity _____ Decline Language _____
 Male Female Marital Status: Single Married Widowed Separated DP
 Spouse/Partner Name _____ Spouse Date of Birth _____
 Patient Home Street Address _____ Apt# _____
 PO Mailing address [if applicable] _____
 City _____ State _____ Zip _____
 Patient Home Phone#[] _____ Cell Phone#[] _____
 Patient email address [please print clearly] _____
 Would you like online access to your health record emailed to you? Yes _____ No _____
 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

If patient is a minor – provide Name of parents or guardian _____
 Address of parents or guardian _____
 Phone #[] _____ Cell phone[] _____
 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 American Express Discover
 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

Have you ever been to a podiatrist before? Yes No

What is your **chief foot complaint** for which you came to be treated?

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 **foot conditions**?
Please check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Ankle Instability | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Anaphylactic reaction | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Bone Spurs | <input type="checkbox"/> Limb Length Discrepancy |
| <input type="checkbox"/> Bunions | <input type="checkbox"/> Neuromas |
| <input type="checkbox"/> Burning Feet | <input type="checkbox"/> Numbness or tingling in feet or toes |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Seizure Disorder Type _____ |
| <input type="checkbox"/> Corns/Callouses | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Flat Feet | <input type="checkbox"/> Sprains |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Fungal Infections (skin/nail) | <input type="checkbox"/> Sweating/Odor |
| <input type="checkbox"/> Hammertoes | <input type="checkbox"/> Swelling (Edema) |
| <input type="checkbox"/> Hepatitis (A, B, or C) | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Heel Pain | <input type="checkbox"/> Ulcers |
| | <input type="checkbox"/> Warts |

MEDICAL HISTORY/FAMILY HISTORY

Have you ever been treated for any of the following conditions? Please all that apply to you;

Put an **M** if on your mother's side;

Put an **F** if on your father's side

- | | |
|-----------------------------------|--|
| _____ Anemia | _____ Heart valve problems |
| _____ Arthritis | _____ Hepatitis |
| _____ Bleeding Disorders | _____ High Cholesterol |
| Type _____ | _____ Hypertension |
| _____ Cancer | _____ Irritable Bowel syndrome |
| Type _____ | _____ Kidney Problems |
| _____ COPD | _____ Stones-infection-disease-failure |
| _____ Depression | _____ Liver Disease |
| Diabetes | _____ Low Blood Pressure |
| # of Years | _____ Neuropathy |
| _____ Type 1 | _____ Peripheral Artery Disease |
| _____ Type 2 | _____ Parkinson's Disease |
| Insulin _____ Yes _____ No | _____ Phlebitis |
| _____ Fibromyalgia | _____ PVD |
| _____ Gout | _____ Psychosis |
| _____ Heart Attack | _____ Rheumatic Fever |
| _____ Heart Blockage | _____ Stomach Ulcers |
| _____ Heart Failure | _____ Varicose veins |

MEDICATIONS

Are you currently on Blood Thinners? Yes No

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

Name of Medication	Strength/Mg	Take how often?

Do you currently use: Cigarettes or Tobacco? Yes Never Quit

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

If quit, when? _____ yrs _____ months

Alcohol use? Yes No If yes, quantity _____ daily _____ weekly

SURGERIES

Please list all surgeries	Approximate Date

Name of MD/Family Physician _____

Address _____

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			Novacaine		
Anti-inflammatory Meds			Peanuts		
Aspirin			Penicillin		
Codeine			Seafood		
Cortisone			Other antibiotics		
Iodine			Other pain medication		
Latex			Other		

If other, please explain _____

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, P.A.**
- ♦ 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.
- ♦ I hereby give permission to **Arp Foot And Ankle Clinic, P.A.** 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 Policy

Payment Policy

Thank you for choosing Arp Foot And Ankle Clinic, P.A. 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 driver's license and 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. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 60 days past due, you will receive a letter requesting immediate payment. A \$10.00 rebilling fee will be charged for each additional invoice sent out after 30 days. 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. Our policy is to charge \$25.00 for missed appointments not canceled within a reasonable amount of time or for an understandable reason. Separate fees will apply for missed surgical appointments. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

9. Forms and Documents. It is our policy to charge \$10.00 for completion of all forms, such as disability applications, etc.

10. Fees. Our fees are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

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

✓

Signature of patient or responsible party

Date

Privacy Statement

The **Arp Foot And Ankle Clinic, P.A.** 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 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)