

ASSOCIATES -

Circle which doctor you're seeing today	: Bean	Carro	Morris	Walker	
First name:	Last name:			M.I.	
What do you like to be called?	Birthdate: Ag		Age:	Gender: M	F
Hamas Adduses		City		Zin:	
Mailing Address:		City:		Zip <u>:</u>	
SS#:	n above)				
Home Phone #	Work #:		Cell#		
E-mail address:					
The following three questions are require	ed by the gover	nment: Race:	Etn	nicity:	
Preferred Language:	☐ I do not wisl	n to answer the	ese questions.		
Your Employer:		Occupation			
Marital Status: S M W D Spouse's N					
Emergency contact:					
Who is your Primary Care Physician ?			Last Date Se	een:	
What Pharmacy do you use?		Location:	Pho	ne #:	
If patient is a minor, please list name of Is your visit due to a motor vehicle acc workers compensation coverage/in	cident/personal surance? □ Yes	injury or an o □No (If yes, pl	n the job injury i	n which you a	
How did you hear about us?					/
If referred, whom may we thank for you					
BILLING INFORMATION: If patient is Relationship to Patient: □Spouse □F Name of Insured: □ Insurance Address: □ Employed by: □ Insurance	not the primary Parent □D BID#: City:	insured, please ivorced ParentIns Gro Zip:	e complete inform Othe urance Co: oup ID#: Phone: ork #:	ation below:	
I authorize treatment and diagnostic proce Oklahoma Foot and Ankle Associates to fur agencies, who are concerned with my hear or injury. I also authorize and assign pays services or supplies provided with the under scan of this authorization shall be consider on this form is true and correct to the best of Signature: [Patient / Responsib	nish my insurance Ith and welfare, w ment of medical l erstanding that an red as effective al of my knowledge.	e company, Medi vith all the neces benefits to Oklal y overpayment d nd valid as the o	care, referring phys sary information renoma Foot and Anlue will be reimburs riginal. I certify tha	ician, or other p garding my pro kle Associates ed to me. A pl at all informatio	professional esent illness for medical noto copy or n contained
(Patient / Responsib	le party)				7/2018

Oklahoma Foot & Ankle Associates

Medical Information (Page	e 1 of 2) Name:	Date:		
How long has it been bothe	ering you?			
		a doctor):		
Trease not any treatment to	i mis condition (of you of	<u> </u>		
Please list any past problem	ns or injuries with your fee	t or ankles:		
		Do you exercise?		
		rint list medications, dosages,		
	you have a list of your m	edications, please let us cop	y it.)	
Medication & Dosage	For what condition?	Medication & Dosage	For what condition?	
•		•		
		•		
		•		
•				
		•		
Dlagga list any Crasiclists	(Finet and I and an are	• '61		
Please list any Specialists y	you see (First and Last nam	ne if known):		
D	D1 1 1 1 1 1 1	1		
Review of Organ Systems		e been told you have or had a		
Blood	Paralysis	Heart Attack (Previous)	<u>Skin</u>	
Anemia	Seizures/Epilepsy	Irregular Beats	8	
Bleeding disorders	Migraine Headaches	Murmur	Keloid/Thick Scar	
Blood Clots	Multiple Sclerosis	Clogged Arteries (Stent)	Psoriasis	
Cancer-	Cerebral Palsy	Pacemaker/Defibrillator	<i>Type?</i>	
What type?	Nervous Disorder	Endocrine	Changing skin lesion	
Musculoskeletal	Peripheral Vascular	Diabetes	Skin Cancer	
Gout	Poor Circulation	How long? yrs.	<i>Type?</i>	
Osteoarthritis	Impotence	Insulin? ☐ Yes ☐ No	Respiratory	
Rheumatoid Arthritis	Calf Pain when walking	Hypoglycemia	Lung Problems	
Other arthritis	Varicose Veins	Hyperthyroid	Asthma	
Joint Stiffness	Phlebitis	Hypothyroid	Bronchitis	
Joint Swelling	Swelling in the legs/feet	Osteoporosis	Emphysema	
Leg Cramps Joint Pain	<u>Psychology</u>	<u>GI</u>	Pneumonia	
Back Pain	Depression/Anxiety	Intestinal disease	Pulmonary Embolism	
Sciatica	Sleep Disturbances	Stomach Ulcers	<u>Infectious</u>	
Hip Pain	Psychiatric Care	Reflux Disease/GERD	Aids/HIV	
Knee Pain	<u>Head</u> Hearing Loss	Kidney	Polio	
Nighttime burning - feet	Macular Degeneration	Kidney Disease/Failure	Tuberculosis	
Cramps of feet	Cataracts/Glaucoma	Kidney Stones	Lyme's Disease	
Neurological	Cardiac Cardiac	Dialysis	Other Problems not	
Neuropathy – feet	Cardiac Congestive Heart Failure	Liver disease	listed?	
Numbness	Heart Disease	<i>T</i>		
Stroke	High Rload Pressure	Type?		

Medical Information	ation (Page 2 of 2) Na	me:		D	oate:	
		e to any medications (or				
	t what it was and you		, ,			
Antibiotics	□ Yes □ No			Mild	Moderate	e Sever
	☐ Penicillin					
Aspirin						
Ibuprofen (Advil)						
NSAIDS						
Medicines						
Codeine/Lortab	□ Yes □ No					
		nt the Dentist)				
Tape						
_	□ Yes □ No					
Latex						
Other						
		ergone:surgery? \(\text{Yes} \(\text{No} - \text{If} \)				
Mother:		ms : Grandparents:Father:				
Social History						
Do you smoke?		Never Packs per day?	How long?		Quit?	
Do you drink alco	hol? 🗆 Yes 🗆 No If	yes, what type and how	much per week?			
Take illegal drugs	?	ny problems with addicti	on / alcoholism ?	□ Yes	□ No	
Shoe Size:	Cı	urrent Weight:		Heigh	t:	
Any additional inf		ike us to know? □ Yes □				_
This information i	s correct to the best o	f my knowledge:				П
			Signature		De	to



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

 Patient's Name/Responsible Party	Date	
I give authorization to relea	se my information to:	
 Name of Person to release to	Relationship to Patient	
 Name of Person to release to	Relationship to Patient	
 Name of Person to release to	Relationship to Patient	
 Name of Person to release to	Relationship to Patient	



FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment. Please understand that payment of your bill is considered your responsibility.

All patient must complete our Information and Insurance form before seeing the doctor.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE
**WE ACCEPT CASH, CHECK, VISA/MASTERCAR, AMERICAN EXPERSS AND DISCOVER

REGARDING INSURANCE

We may accept assignment of insurance benefits. However, we do require a portion of the bill at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance. We are not a party in that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other medical insurance companies.

Regarding insurance plans where we are a participating provider: All co-pays and deductible are due the day of treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider please refer to the above paragraph.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary.

ADULT PATIENT

Adult patients are responsible for full payment at the time of service.

MINOR PATIENTS

The adult accompanying a minor and the parents (or legal guardian of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been paid by Visa/MasterCard, American Express, Discover, Personal check or Cash at the time services are rendered.

REGARDING X-RAYS

The fee you pay for x-rays is for **processing and primary interpretation**, not for the actual copy. Should you need copies of your x-rays taken in this office, please make your request to the nurse.

	tonogramma and agree to	o this Financial I oney.	
X		DATE:	
	(SIGNATURE OF PATIENT OR RESPONSIBLE PARTY)		

I have read the Financial Policy. I understand and agree to this Financial Policy.



NOTICE OF POSSIBILITY OF INSURANCE DENIAL FOR DURABLE MEDICAL EQUIPMENT

Your insurance company will only pay for a service that it determines to be reasonable and necessary. If your insurance company determines that an item or service is not reasonable and necessary under your insurance program standards, they will deny payment for that item or service. It is possible that your insurance company may deny payment for **DURABLE MEDICAL EQUIPMENT** include, but are not limited to:

- Ankle Braces
- Night Splints
- Removable Walking Boots
- Orthotics
- TENs units

Even if your doctor feels you need this DURABLE MEDICAL EQUIPMENT for proper healing of your condition, your insurance company may consider the above item not medically necessary, or they may consider it a non-covered item under your plan policy.

I've have been informed by my physician that in my case, my insurance company may deny payment for the services identified above, for the reasons stated. If my insurance company denies payment, I agree to be personally and fully responsible for payment.

Patient Name:	
Patient Signature:	
Date:	

600 W. 15th Street, Edmond, OK 73013

3001 S. Telephone Rd, Suite B, Moore, OK 73160

2801 Parklawn Dr., Ste. 201, Midwest City, OK 73110