SureStep
Foot & Ankle Medical Center

New Patient Registration

Demographics

First Name	Middle Initial	Last Name	Preferred Name /Nickname	Gender
				☐ Male ☐Female

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

Date of Birth	Driver's License State & Number	Social Security Number	Primary Phone	Secondary Phone

Emergency Contact	Emergency Contact Phone	My Emergency Contact is my:
		☐ Spouse ☐Relative ☐Friend ☐Other

Employment Status	Employer / School	Work Phone	Personal Email Address
☐ Full-Time ☐Part-Time ☐Retired ☐Student ☐Other			

How Did You Hear About Us?	Primary Care Physician (PCP)	PCP Phone	Date of Last Visit
☐ Internet ☐Hospital ☐Insurance Company ☐Friend ☐Referred By Primary Care Physician			

Ethnicity	Primary Language	Race
☐ Hispanic/Latino ☐Non-Hispanic/Latino	☐English ☐Spanish ☐ German ☐Russian ☐ Other	☐Asian ☐African American ☐ Caucasian ☐ Other

Insurance & Payment Information

Primary Insurance Company	Policy Holder's Name	Policy Holder's Social Security Number	Policy Holder Date of Birth	Patient's Relationship to Policy Holder
Secondary Insurance Company	Policy Holder's Name	Policy Holder's Social Security Number	Policy Holder Date of Birth	Patient's Relationship to Policy Holder

Is this injury the result of…

☐ A work-related injury → BWC Claim #: ____________________________ Date of Injury: ___________________

☐ A car accident → Claim #: _________________________________ Date of Accident: ________________

<u>If you have insurance:</u> We participate in most insurance plans, including Medicare and Medicaid. 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. Health plan coverages vary significantly by carrier, employer and/or by contract. We cannot know the benefits and exclusions of each patient's health plan. Knowing your insurance benefits is <u>your</u> responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

- **Proof of Insurance**: a copy of your driver's license and current valid health insurance cards are required at time of visit.
  - If you are unable to provide proof of insurance you will be held responsible for the services in <u>full at time of treatment</u>.
  - If your health insurance coverage is active during the time of your visit, the insurance company will be billed and only after receiving payment for the services will any balance be refunded.
  - If you fail to provide us with the correct insurance at the time of each applicable visit, you may be responsible for the balance of a claim.
  - Please be aware that some – and perhaps all – of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
- **DME Coverage:** Prior authorization is obtained for DME when required, but this is not a guarantee of payment. Your insurance will make the final determination of eligibility, allowances, plan limitations and disposition after the claim is received. <u>This may become patient responsibility</u>. If you have additional questions regarding coverage, please contact your insurance company.
- **Referrals**: 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.
- **<u>If you do not have insurance:</u>** Payment is due in full at time of visit.

_______________________________________ _______________________
Patient Signature Date

Medical/Health Questionnaire:

Height	Weight	Shoe Size	Are You A Diabetic?	Do You Drink?	Do You Smoke?	Pregnant?
			☐No ☐Yes	☐No ☐Yes: ____ drinks per week	☐Yes ☐No ☐Former Smoker	☐Yes ☐No ☐N/A-Male ☐Possibly

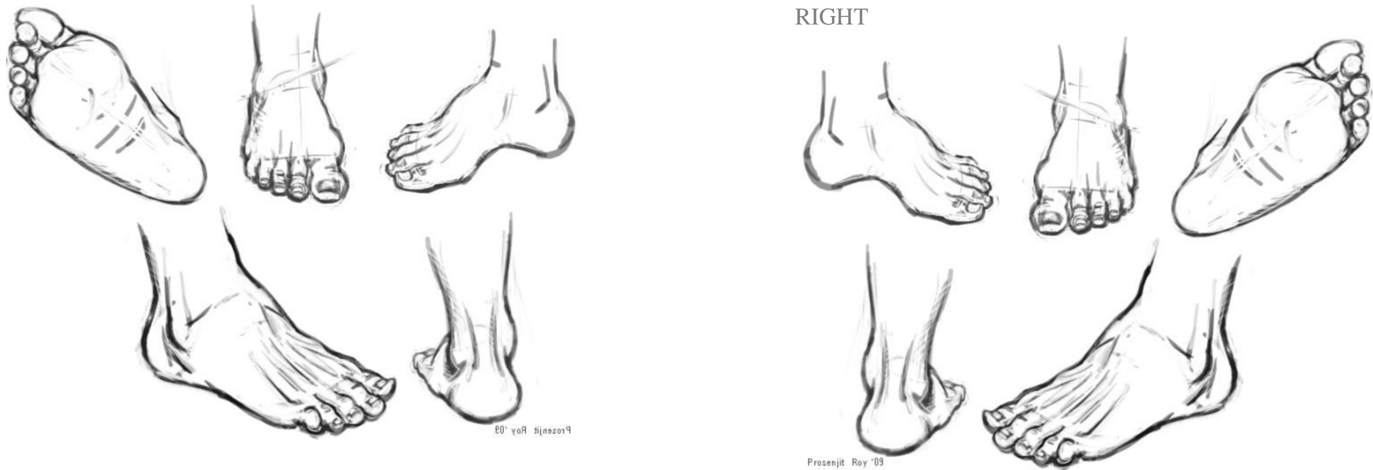
Please list any major surgeries you have had (and approximate date):	

Please list all current medications (*If you have a list of current medications, please provide it to the front desk so we can ensure your chart is accurate/ complete)*

Medication:	How much do you take?	How often do you take it?	What do you take this medication for?

What is your primary reason for coming to see us today?

Please circle area(s) of concern:



Allergies:	☐Latex ☐Penicillin ☐Aspirin ☐Codeine ☐Sulfa Drugs ☐Metals/Jewelry ☐Food Allergies ☐Environmental Allergies ☐NO ALLERGIES ☐Other: ________________________________
Major Illnesses:	☐AIDS/HIV ☐Diabetes ☐Epilepsy ☐Fibromyalgia ☐Gout ☐Heart Disease ☐Heart Murmur ☐High Blood Pressure ☐Rheumatoid Arthritis ☐RSD ☐Seizures ☐Shingles ☐Stroke ☐Thyroid Disease ☐Cancer ☐Other: __________________________
Gastro:	☐Acid Reflux ☐Bladder Infections ☐Colitis ☐Crohn's ☐GI Bleeding ☐Hiatal Hernia ☐IBS/IBD ☐Kidney Infections ☐Kidney Stones ☐Liver Disease ☐Prostate Disease ☐Rectal Bleeding ☐Ulcers
Skin:	☐Keloids ☐Psoriasis ☐Current Rash/Sores ☐Other: ___________________
Respiratory & Head:	☐Asthma ☐Bronchitis ☐Emphysema ☐Glaucoma ☐Hearing Deficit ☐Frequent Migraines ☐Recent Pneumonia ☐Sinus Infections ☐Tonsillitis ☐Other: __________________________
Musculoskeletal	☐Gout ☐Joint Implants ☐Osteoarthritis ☐Rheumatoid Arthritis ☐Other: __________________________
Psychological:	☐Anxiety ☐Bipolar ☐Depression ☐History of Drug or Alcohol Abuse ☐PTSD ☐Other: ____________________
Vascular:	☐Anemia ☐Clotting Disorder ☐Hemophilia ☐Phlebitis ☐PVD (Peripheral Vascular Disease) ☐Reynaud's ☐Sickle Cell ☐Spider Veins ☐Varicose Veins ☐Other: ____________________

Office/Payment Policies & Fees:

Co-payments and Deductibles: All co-payments and deductibles must be paid at the time of service.
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 BEFORE each visit.

- This arrangement is part of your insurance plan with your insurance company. We sign a contract with each insurance company which includes the commitment to collecting all co-payments and deductibles. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the federal law by paying your co-payment BEFORE each visit.
- If you are unable to pay your copay prior to your appointment you will be rescheduled and you will be CHARGED A $35.00 FEE to cover our administrative and office costs. Please come prepared to pay your co-pays each visit. All co-payments and deductibles must be paid at the time of service. Co-payments and deductibles are part of your contract with your insurance company. If you disagree with any aspect of billing charges, co-payments, deductible and/or coverage, we suggest you contact your insurance company as we do NOT have the ability to alter any of these monies.

Claims submission: We will submit your claims in a timely manner; 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.

Check Writing/Fee*:* We do accept personal checks. Returned checks generate an insufficient funds fee of $37.50 and will apply in addition to you original payment amount. A valid credit card will be required for all future payments.

Payment: We accept American Express/Discover/MasterCard/Visa/HSA Card/CareCredit/Checks.

- A monthly $10 or 10% (whichever is greater) administrative late fee will be added to all accounts 21+ days overdue.
- ALL account balances which are **60+days** overdue, will incur a 35% Administrative Fee or $35.00 fee, whichever is greater, and will immediately be sent to collections.

Prescription Requests: We ask that you address your prescription needs at your appointment. All after hours phone calls/messages will NOT be addressed until the following business day. All physicians at SureStep prescribe Narcotic Medications only in cases of acute injury and after surgery for a pre-stated period of time. If you require long term pain control, you will be referred to a Pain Management Specialist.

Forms and Documents:

- We can provide our standard Restrictions/Limitations document or Appt Verifications for Schools/Employers.
- ALL other forms & documents require the doctor's review, verification and signature. There is a $25 fee for the completion of any forms you request of us. This includes forms such as Disability Applications, Work Releases, FMLA, and Summary Letters.
- Completion of these forms require Dr. Barens to review your records, review & complete the form(s), and for our staff to then input the information being provided to you into our system. As such, we require a minimum of 72 hours' notice to be provided for all paperwork requests-including copies of medical records. Should you require your forms/paperwork sooner than 72 hours, a $15 rush fee will be added.

Missed Appointments: We strive to be on time for your scheduled appointments, and ask that you give us the courtesy of a call when you are unable to keep your appointment. If you arrive 10 minutes past your scheduled appointment time, it may be necessary for us to reschedule your appointment and a Missed Appointment Fee may apply.

24-hours' notice is required to cancel or reschedule so that we can give your appointment to another patient. Messages can be left for appointment cancellations 24/7. We ask that you keep track of your appointments when you make them, as reminder calls are provided as a courtesy - Not receiving your reminder call is NOT a valid excuse for missing an appointment.

	Routine Visit	Appt w/ Ultrasound	Surgical Procedure Appt	Appt w/ AFO Casting	Appt w/ Minor Procedure	Pre-Op Appt	< 90 day Post-Op Appt	>90 day Post-Op Appt
1st Missed	$10.00	$ 30.00	$ 100.00	$ 45.00	$ 30.00	$50.00	$50.00	$ 30.00
2nd Missed	$25.00	$ 50.00	$ 150.00	$ 75.00	$ 50.00	$75.00	$50.00	$ 50.00
3rd + Missed	$40.00	$ 50.00	n/a	$ 100.00	$ 75.00	n/a	$75.00	$ 75.00

Please note that 3 missed appointments in any given 9 month period, or failure to pay Missed Appointment Fees will result in you being discharged from the practice.

Permission to Treat / Release of Information/Privacy Practices: I HEREBY give my permission to the SureStep Foot & Ankle physicians to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my condition. I HEREBY assign to Dr. Barens all benefits provided by my insurance company policy/policies for medical & surgical care. I HEREBY acknowledge Receipt of Notice of Privacy Practices. I have been provided a copy of the Notice of Privacy Practices (available on website & posted in office) and I have read (or had the opportunity to read if I so choose) and understood the Notice.
I AUTHORIZE SureStep Foot & Ankle to call me for appointments, follow-up of treatment or outstanding issues: ☐Phone ☐Email ☐Mail ☐All

______________________________ Patient Signature

____________________ Date