Prestige Foot and Ankle Center

Dr. Richard Limperos DPM, ACFAS
Dr. Lisa Smith DPM, ACFAS
Dr. Kelly Kubiak DPM, ACFAS

Patient Full Name_______________________________ Phone Number___________________________

Address_______________________________City_________________State_________Zip____________

May we leave medical information on the phone number you have provided for us? Yes___ No ___

DOB______________ Age_______ Sex_______ SS#_____________________

Primary Language___________________ Race_______________________

Please circle one ethnicity: Hispanic/Non-Hispanic

Marital Status-S M D W Sep. Spouse's name_________________ Referred By_____________________

Your Employer___________________________Phone_____________________________________

Emergency
Contact/Relationship_________________________________Phone______________________________

Family Physician____________________________ Date of Last Visit______________________________

Party Responsible for Payment of Account____

Preferred Pharmacy_______________________Location____

What specific problem brings you to our office today?

____

____

Have you been seen by a podiatrist or other doctor for this issue? YES NO __________________________

Please specify which ankle/ foot: L R BOTH

Was this a work-related injury? YES NO (If yes, make sure you've provided information for claim)

Height__________ Weight___________ Shoe Size____________ Are you pregnant? YES NO

Allergies and Reactions

____

Do you have diabetes? YES NO If yes, are you on insulin? YES NO

***Most Recent A1C Lab Value _______ Date: _______ Do you smoke? YES NO

Medical History

Have you had any of the following?

Acid Reflux	Y	N	Hepatitis: A B C	Y	N	Skin Ulcer	Y	N
Anemia	Y	N	High Blood Pressure	Y	N	Sleep Apnea	Y	N
Arthritis	Y	N	HIV+/AIDS	Y	N	Stomach Ulcers	Y	N
Artificial Joints	Y	N	Kidney Disease	Y	N	Stroke	Y	N
Artificial Heart Valve	Y	N	Liver Disease	Y	N	Swelling Foot/Ankle	Y	N
Asthma	Y	N	Low Blood Pressure	Y	N	Taken Blood Thinners	Y	N
Blood Clots	Y	N	Psoriasis	Y	N	Thyroid Disease	Y	N
Cancer	Y	N	Neuropathy	Y	N	Poor Circulation	Y	N
Gout	Y	N	Open Sores	Y	N	Depression	Y	N
Fibromyalgia	Y	N	Sickle Cell Disease	Y	N	High Cholesterol	Y	N
Heart Attack	Y	N	Seizures	Y	N	Other Conditions?	Y	N
Heart Disease/Failure	Y	N	Skin Disorder	Y	N		Y	N

Are you currently in Pain Management? Yes No if yes, name of Doctor____

Current Medications, Dosage, and Instructions (Include Prescriptions, Over-the-Counter Meds and Herbal Supplements.)

____

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Previous Surgeries/Hospitalizations (Type and Date)

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ACKNOWLEDGMENT & CONSENT

Must be signed by all patients or guardians prior to being seen by physician

I certify that the information is true and correct to the best of my knowledge. I give permission to the doctor to examine, photograph, x-ray, administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problems.

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Person(s) Authorized to inquire about patient information; may include billing information, appointments, or medical questions

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Name of Person/Relationship to patient

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Name of Person/Relationship to patient

By my signature below, I acknowledge that I have been presented with Prestige Foot & Ankle Center's Notice of Privacy Practices, the Financial Policy and the Patient Authorization regarding Protected Health Information.

___________________________________ ___________________________________

Print Name of Patient, Parent or Guardian **Signature/Date**

Notice of Privacy Practices – Acknowledgment & Consent

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Prestige Foot & Ankle Center or may be disclosed to others for purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of Protected Information in violation of an agreement upon restriction will be a violation of the Federal Privacy Standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

PRESTIGE FOOT & ANKLE CENTER, LLC
FINANCIAL POLICY

INSURANCE: If you are not insured by a plan we participate in you are responsible for out of network rates. 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.** Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company. **We do participate in several PPOs, Medicare, and Medicaid programs, however; it is the responsibility of the patient to verify if we are In-Network providers with their insurance company. New patients' insurance cannot be filed unless we receive a copy of the insurance card and driver's license on the first visit. In addition, it is the patient's responsibility to manage referrals/authorizations if required by his/her insurance carrier.**

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

COPAYMENTS AND DEDUCTIBLES: All co-payments and deductible must be paid at the time of service. If you do not have your co-payment at the time of your service, you will be charged a $10 processing fee. 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.

SELF PAY/CASH PAY: Payment in full is due at the time of service and we accept the following payment methods: Cash, Check, VISA/MasterCard/American Express/Discover, and Debit Card. Hardship program is offered to those who qualify; a 20% discount is taken if payment in full is made the day of service.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. **You are responsible for payment of these services.**

WORKERS COMPENSATION: This office is a certified Ohio Bureau of Worker's Compensation and accepts approved claims. Any Disallowed Claim fees will be the patient's responsibility

BILLING SERVICE:
Prestige Billing Network will be processing all claims and sending statements. Please phone our billing service at **330-944-2800** for any questions concerning your statement balances and payments made on your account. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

DELINQUENT ACCOUNTS/COLLECTIONS: Account balances over 90 days will be sent to collections after no response from the patient. Statements will be mailed once per month for three months before becoming delinquent. **It is the patient's responsibility to inform the staff of any changes in address or insurance information.**

ADMINISTRATIVE SERVICE FEES: It is our office policy that we require administration fees to be paid before the completion of any FMLA, Disability, Patient Assistance, or Unemployment forms. Fees will vary per form and will cover a single diagnosis per global period.

NO-SHOW POLICY: **We understand there are times when you must miss an appointment due to an emergency. However, when you fail to cancel after your second no-show you will be charged a $50 fee; this will not be covered by your insurance company. We reserve the right to withhold scheduling you for further appointments and will help you find another provider.**

I agree to be responsible for payment of all services rendered on my behalf or that of my dependents. I acknowledge and accept this Financial Policy
I have read the above policy regarding my *financial responsibility* to **Prestige Foot & Ankle Center, LLC** for medical services provided. I agree to pay **Prestige Foot & Ankle Center, LLC** any balance unpaid by my insurance carrier for myself or the below named person. I understand that I will be responsible for balances if insurance has not responded in 90 days.

ASSIGNMENT OF BENEFITS:
I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Prestige Foot & Ankle Center, LLC,** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care.