Teton Foot and Ankle Center

Welcome To Our Office

Patient Information

Patient Account # | Date | Social Security #

Name (Last, First, M.I.) | Date of Birth | Gender M / F | Marital Status M / S / D / W

Mailing Address | City | State | Zip

Home Phone | Cell Phone

Place of Employment | Work Phone

Parent / Person Responsible for Account | Responsible Person's Date of Birth

Mailing Address | City | State | Zip

Home Phone | Cell Phone

Patient Info: Race ☐ African American ☐ Native American ☐ Caucasian ☐ Other_____ ☐ Asian ☐ Mexican

Ethnicity ☐ Hispanic/Latino ☐ Mexican ☐ Pacific Islander ☐ Other_____ _____

Primary Insurance Information

Primary Insurance Company | Address | Co-Pay Amount

ID # | Group #

Policyholder Name | Date of Birth | Social Security #

Secondary Insurance Information

Primary Insurance Company | Address | Co-Pay Amount

ID # | Group #

Policyholder Name | Date of Birth | Social Security #

Office Policy: Your co-pays, deductibles or percentages are due at the time of service. We file insurance claims on your behalf. However, you are responsible for all deductibles and charges not covered by insurance. Please keep us informed of all changes to your coverage. All collection costs and attorney fees are your responsibility if not paid as agreed. I have read the above and accept financial responsibility for this account.

Authorization: By signing this, I authorize release of any/all medical records regarding my care to another physician/facility. I understand that this medical information may be used for Diagnostic, Insurance, Legal and other reasons as deemed necessary by Teton Foot and Ankle Center to ensure the best medical care on my behalf.

Signature X_____ Date_____

Minor Patients Only

I authorize Teton Foot and Ankle Center to treat minor patients when NOT accompanied by parent or legal guardian.

Signature X_____ Date _____

Emergency Contact Information (Person not living with you) | Phone ( )

Medical Information

Patient Age

What current foot / ankle problem has brought you to our office today?_____

_____

Referring / Current Physician

First Name Last Name MD / DO /PA / NP Office Phone #

( )

Pharmacy Name and Location:

Medications Please list all prescription and over-the-counter medications you are currently taking (including herbal):

_____

_____

_____

Allergies: (Please check all known allergies you may have.)	☐ ADHESIVE TAPE ☐ LOCAL ANESTHETICS ☐ METALS ☐ SOYBEANS	☐ NOVOCAINE ☐ CODEINE ☐ PENICILLIN ☐ SULFA	☐ EGGS ☐ SHELLFISH ☐ LATEX ☐ ASPIRIN	☐ OTHER_____ ☐ OTHER_____ ☐ OTHER_____

General Medical History:	☐ AIDS/HIV ☐ ANEMIA ☐ ARTHRITIS/RHEUMATOID ☐ ARTHRITIS/OSTEOARTHRITIS ☐ BACK PROBLEMS ☐ CHEMICAL DEPENDENCY ☐ DIABETES ☐ FAINTING ☐ HEADACHES, CHRONIC ☐ HEPATITIS ☐ LEG CRAMPS ☐ NERVOUS PROBLEMS ☐ RADIATION TREATMENT ☐ RHEUMATIC FEVER ☐ SWELLING, ANKLE(S), CHRONIC	☐ TB ☐ VARICOSE VEINS ☐ ALLERGY TO ANESTHETICS ☐ MRSA ☐ ARTIFICIAL HEART VALVE ☐ BLEEDING DISORDERS ☐ CHEST PAIN ☐ DIARRHEA, CHRONIC ☐ FOOT CRAMPS ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ LIVER DISEASE ☐ PHLEBITIS ☐ RASH, CHRONIC ☐ SHORTNESS OF BREATH ☐ PSYCHIATRIC DISORDERS	☐ SWELLING, FOOT, CHRONIC ☐ ULCERS, SKIN ☐ VENEREAL DISEASE ☐ ASTHMA ☐ CANCER ☐ CIRCULATION PROBLEMS ☐ EPILEPSY ☐ GOUT ☐ HEMOPHILIA ☐ KIDNEY PROBLEMS ☐ LOW BLOOD PRESSURE	☐ RESPIRATORY DISEASE ☐ STROKE ☐ SWELLING, LEG(S), CHRONIC ☐ ULCERS, STOMACH ☐ WEIGHT LOSS, UNEXPLAINED SMOKER: ☐ YES ☐ NO ☐ NEVER

List any surgeries and hospitalizations you have had (both major and minor): _____

_____

_____

_____

Consent: I certify that the above information is true and correct to the best of my knowledge.
I give my permission for Dr. Michael K. James to examine, photograph, administer and perform such minor operative procedures as may be deemed necessary in the diagnosis and /or treatment of my foot and/or ankle problems.

X_____ Date_____

Teton Foot & Ankle Center
Michael K. James, DPM

3345 South Holmes Avenue
Idaho Falls, Idaho 83404
208-528-2858

Financial Policy

Thank you for choosing us as your Podiatric Provider. The purpose of this policy is to empower you by giving you a clear understanding of your financial responsibility with regard to any and all shared costs, co-pay amounts, deductibles, and any balance not paid by your insurance or employer plan.

Self-Pay
If you are uninsured, all fees are required at the time of service. We accept all major credit cards.

Insured
We will bill your insurance for you, but deductibles, co-payments and coinsurance are due at the time of service. All major credit cards are accepted for your convenience. Your insurance may pay more or less than we expect and you will be responsible for any remaining balance. If we have not had a response from your insurance company within 30 days (as required by state law), you will be sent a bill for the remaining balance. We request that you take an active role in getting your insurance company to pay your claim.

Insurance Denials/Surgery
As a safeguard, our facility will contact your insurance company to pre-authorize, pre-notify, and/or pre-certify any surgery(s) you may choose to have. This action is required by most insurance carriers but it does not result in a guarantee of payment. Please be advised that unless contractual arrangements affect your liability for payment, you are responsible for your bill. Your insurance company may claim that your recommended surgical procedures lack medical necessity, are investigational, or use another form of denial tactic. By signing this form, you agree that should your insurance company deny payment for services that you have chosen to have, you will take responsibility for all charges incurred.

Delinquent Accounts
You agree to pay cost and/or reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection or suit. If it becomes necessary to collect an account by legal action, the responsible party will need to pay ALL fees involved.

Returned Checks
If payment by check is returned for Non-Sufficient Funds, you will be charged a $20.00 fee along with the total of the check to be paid in full.

Divorce
In case of a divorce, Dr. James is not party to the divorce settlement. If your ex-spouse is obligated to pay, that is up to you to enforce, not the doctor.

Missed Appointments
We would appreciate 24 hours notice for the cancellation of an appointment except in an emergency situation. After two missed appointments without 24 hours notice, you will be charged a $25.00 missed appointment fee.

Overpayments
Overpayments will be returned to the patient/guarantor after completion of all insurance billing.

Thank you for trusting us with your care. Please feel free to contact our office at 528-6225 with any questions you may have regarding financial responsibilities.

X_____Date_____
(Signature of Patient or Parent/Guardian)

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the Notice of Privacy Practices.

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information
We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization
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.

Uses and Disclosures Not Requiring Your Authorization
In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care
- For certain limited research purposes
- For purposes of public health and safety
- To Government agencies for purposes of their audits, investigations and other oversight activities
- To Government authorities to prevent child abuse or domestic violence
- To the FDA to report product defects or incidents
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas and as otherwise required by law

Patient Rights
As our patient, you have the following rights:

- To have access to and/or a copy of your health information
- To receive an accounting of certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence
- To request that we amend your health information
- To receive notice of our privacy practices

I authorize the release of information to the following person(s):_____

_____

I acknowledge that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____
Patient Name (Print) Date

_____
Signature (Patient or Guardian)