



**FINANCIAL INFORMATION**

Is the patient responsible for all bills? \_\_\_\_\_

**If no then:**

\*\* Guarantor \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**INSURANCE INFORMATION – WE WILL ALSO COPY YOUR CARDS UPON CHECK IN PLEASE PROVIDE THE INSURED’S DATE OF BIRTH**

Primary Insurance Company Name \_\_\_\_\_

Insured’s Name \_\_\_\_\_ Insured’s date of birth \_\_\_\_\_

Relationship to subscriber \_\_\_\_\_

Secondary Insurance Company Name \_\_\_\_\_

Insured’s Name \_\_\_\_\_ Insured’s date of birth \_\_\_\_\_

Relationship to subscriber \_\_\_\_\_

**CURRENT FOOT PROBLEM**

Please describe your foot problem \_\_\_\_\_

Which foot is affected? \_\_\_\_\_ Right \_\_\_\_\_ Left \_\_\_\_\_ Both

How long ago did this problem first start ? \_\_\_\_\_ days/weeks/months/years

Did your pain or problem \_\_\_\_\_ Begin all of a sudden \_\_\_\_\_ Gradually develop over time

How would you describe your pain? \_\_\_ No pain \_\_\_ Sharp \_\_\_ Dull \_\_\_ Aching \_\_\_ Burning \_\_\_ Radiating

\_\_\_ Itching \_\_\_ Stabbing \_\_\_ Other \_\_\_\_\_

How would you rate your pain scale from 0 to 10? (Please circle)

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

Since your pain or problem began, has it \_\_\_ Stayed the same \_\_\_ Became worse \_\_\_ Improved

What makes your pain or problem feel worse? \_\_\_ Walking \_\_\_ Standing \_\_\_ Daily activities \_\_\_ Resting

\_\_\_ Dress shoes \_\_\_ High heels \_\_\_ Flat shoes \_\_\_ Any closed toe shoe \_\_\_ Running

\_\_\_\_ Other \_\_\_\_\_

What makes your pain feel better? \_\_\_\_\_

What treatments have you had for this problem? \_\_\_\_\_

How long has this problem affected your lifestyle or ability to work? \_\_\_\_\_

Was this problem caused by an injury? \_\_\_\_ no \_\_\_\_ yes – describe \_\_\_\_\_

\_\_\_\_\_ If yes, was it work related? \_\_\_\_\_

Is this condition causing or are you suffering with any of the following:

Tingling/numbness in:

Pain radiating into:

Weakness of the:

\_\_\_\_ Legs R/L

\_\_\_\_ Ankle R/L

\_\_\_\_ Legs R/L

\_\_\_\_ Ankle R/L

\_\_\_\_ Feet R/L

\_\_\_\_ Ankle R/L

\_\_\_\_ Feet R/L

\_\_\_\_ Toes R/L

\_\_\_\_ Foot R/L

Difficulty with:

\_\_\_\_ Standing

\_\_\_\_ Bending

\_\_\_\_ Walking

\_\_\_\_ Lifting

\_\_\_\_ Sitting

\_\_\_\_ Kneeling

How much are you on your feet at work? \_\_\_\_ 10% \_\_\_\_ 25% \_\_\_\_ 50% \_\_\_\_ 75% \_\_\_\_ 100%

Exercise: \_\_\_\_ Never \_\_\_\_ Rare \_\_\_\_ Occasional \_\_\_\_ Weekly \_\_\_\_ Several times a week  
\_\_\_\_ Daily

Type of exercise \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_ Width \_\_\_\_\_





**CONSENT:**

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. I REQUEST AND AUTHORIZE ACADIANA FOOT CENTERS TO DIAGNOSE AND ADMINISTER TREATMENT FOR MY CONDITION.

PATIENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

## ACADIANA FOOT CENTERS FINANCIAL POLICY

We at Acadiana Foot Centers are committed to providing you with the best possible care. If you have Medical Insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding on our payment policy.

1. Full payment is expected on the day medical services are provided unless you have health insurance coverage with a plan that we have a written agreement with. Our financial policy offers you a number of payment options such as: cash, check, Visa, MasterCard and Discover. Patients with insurance must pay, when applicable: **Deductible**- an amount you must pay first out of your own pocket each year before insurance will pay for any services. **Co-payment**-an amount you must pay upon each visit to a doctor that is due at the time of service. **Co-insurance**-an amount which usually is a percentage of the fee that your insurance company will not pay. Deductibles, co-payment and co-insurance are patient responsibility. Custom orthotics require a deposit of \$100.00 and \$60.00 casting fee at the time of casting. The balance is to be paid upon orthotic dispense.
2. Insurance is a contract between you and your insurance company.
3. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.
4. It is your responsibility to ensure that our physician is in your insurance network.
5. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our providers.
6. Payment is due for rendered services 10 days from receipt of your billing statement. Unpaid previous balances must be paid in full prior to any additional visits, unless arrangements have been made with our financial counselor.
7. The returned check fee is \$25.00.
8. Administrative Services: There is a \$25.00 charge for forms completion for family medical leave and disability.
9. Workman's Compensation – We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.
10. Personal Injury – If you are being treated as part of a personal injury lawsuit or claim, payment of the bill remains the patient's responsibility. Even if a personal injury claim or lawsuit is pending.
11. All sales are final with over the counter or DME items.

12. Not all services are a covered benefit in all contracts. Some insurance companies refuse to cover certain services. We have no control over this.

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

Printed Patient Name: \_\_\_\_\_

Patient Spouse/Parent/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Spouse/Parent/Guarantor Name \_\_\_\_\_



**ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION**

If I am entitled to benefits under the Medicare, the Medicaid or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me), in consideration for services provided to me by Acadiana Foot Centers, I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered to me. I authorize payment of benefits directly to Acadiana Foot Centers, with such benefits to be applied to my bill. **I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts, deductibles, Durable Medical Equipment and any charges for services deemed to be non-covered, not pre-certified or not pre-authorized by my insurance plan.**

\_\_\_\_\_ (initial) I give my consent for examination and treatment by Acadiana Foot Centers

\_\_\_\_\_ (initial) I acknowledge that I was provided or offered a copy of the Notice of Privacy Practices and that I have read and understand this form

\_\_\_\_\_ (initial) I acknowledge that I have received and read the Financial Policy of Acadiana Foot Centers

I, \_\_\_\_\_ hereby give my permission for the persons stated below to discuss my financial and medical records, and discuss my treatment and diagnoses with Acadiana Foot Centers.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**HIPPA High Tech Form – Automated Opt In**

Acadiana Foot Centers is initiating an automated appointment reminder system. The system has the capability of reminding you by email or phone.

We are also updating our records with email addresses so that we may send you appointment reminders.

I authorize the use of an automated appointment reminder system to remind me of upcoming appointments. I understand that signing below signifies my intention to opt in. I understand that I may opt out at any time.

Email address \_\_\_\_\_

Signature \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_