Foot & Ankle Center of Florida LLC

2400 Harbor Blvd. Suite 11 Port Charlotte, FL 33952-5038
P: 941-500-2088 Fax: 941-500-2089
Email: FootAnkleCenterFL@comcast.com

NEW PATIENT INSURANCE REGISTRATION FORM

Patient Information:	
Name:	Date of Birth: Sex: ○ Male ○ Female
Address in Florida: City: State: ZIP:	Home #: ( )
Other Address if Outside of Florida: City: State/Country: ZIP:	Other #: ( )
Social Security #:	Cell #: ( )
Email address:	Other #: ( )

Marital Status:
- ○ Single
- ○ Married
- ○ Divorced
- ○ Widowed
- ○ Separated

Sexual Orientation:
- ○ Heterosexual
- ○ Homosexual
- ○ Bisexual
- ○ Other

Sexual Activity:
- ○ Monogamous
- ○ Polyamorous
- ○ Swinger

Race:
- ○ Unreported/refuse to provide
- ○ Asian
- ○ Native American/Alaskan Native
- ○ Pacific Islander/Other
- ○ Black/African American
- ○ Hispanic/Latino
- ○ White/Caucasian (Not Hispanic/Latino)
- ○ other: Please specify:_____

Languages:
- ○ Spanish
- ○ German
- ○ French
- ○ Italian
- ○ Korean
- ○ Chinese
- ○ Vietnamese
- ○ Haitian
- ○ Russian
- ○ Arabic
- ○ Other:_____
- ○ Brail
- ○ Sign Language

Ethnicity:
- ○ Hispanic
- ○ Not Hispanic or Latino
- ○ Refuse to Report

Employment History:
- ○ Employed By:_____
- ○ Fulltime ○ Part Time
- ○ Self Employed
- ○ Not Employed
- ○ Student. Name of School:_____

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GUARANTOR INFORMATION	
Name:	Date of Birth: Sex: ○ Male ○ Female
Address: City: State: ZIP:	Home #: ( )
Other Address: City: State: ZIP:	Other #: ( )
Social Security #:	Cell #: ( )
Email address:	Other #: ( )
EMERGENCY CONTACT IF ANY DESIGNATED	
Name:	Date of Birth: Sex: ○ Male ○ Female
Address: City: State: ZIP:	Home #: ( )
Other Address: City: State: ZIP:	Other #: ( )
Social Security #:	Cell #: ( )

INSURANCE INFROMATION	
○ Insured ○ Noninsured ○ Self Pay ○ Workers Compensation Case	
Primary Insurance:	Secondary Insurance:
Certificate #:	Certificate #:
Group #:	Group #:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:
Subscriber Relationship:	Subscriber Relationship:
If Workers Compensation case:	
Date of Injury:	
Case # assigned:	
Work Compensation Case Manager Assigned:	
Lawyer if any assigned:	
Was it Reported to Employer:	○ Yes ○ No. Date Reported:
To who was report made: Their Name and title:	

FOOT & ANKLE CENTER OF FLORIDA LLC

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PRIMARY CARE PROVIDER	
Name of Provider:	
Address:	
Phone #:	
Email:	
VASCULAR PROVIDER	
Name of Provider:	
Address:	
Phone #:	
Email:	
CARDIOLOGIST PROVIDER	
Name of Provider:	
Address:	
Phone #:	
Email:	
NEUROLOGIST PROVIDER	
Name of Provider:	
Address:	
Phone #:	
Email:	
ENDOCRINOLOGIST PROVIDER	
Name of Provider:	
Address:	
Phone #:	
Email:	
PHARMACY USED	
Pharmacy name:	
Address:	
Phone #:	
Email:	
HOSPITAL USED/CHOICE	
Name of Provider:	
Address:	
Phone #:	
Email:	
LABORATORY USED	
Name of Provider:	
Address:	
Phone #:	
Email:	
DIALYSIS CENTER USED:	
Address /Phone#:	

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AUTHORIZATIONS

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Foot & Ankle Center of Florida LLC when he accepts assignment.

Patient Signature:	Date:

Authorization to Release Medical Information: I hereby authorize my Provider, Foot & Ankle Center of Florida LLC to release any information necessary for my course of treatment.

Patient Signature:	Date:

I am aware of my HIPAA Rights and have been made aware of them by Foot & Ankle Center of Florida LLC providers and staff. I have been afforded the opportunity to read them in the office or to have them printed out for me at the reception desk.

Patient Signature:	Date:

I allow for copies of my records, insurance card, driver's license, personal picture of myself for records keeping and any digital image or recordings documenting my care, labs reports, x-rays or other diagnostic modalities to be used for reporting to insurance, governmental regulatory agencies, teaching purposes or publications where warranted or deemed necessary by Foot & Ankle Center of Florida LLC. I agree that students, residents, fellows, interns, technicians, assistants, other physicians or allied providers may observe or be involved in my care as long as they are supervised by appropriate faculty or a member of Foot & Ankle Center of Florida LLC staff designated as such.

Patient Signature:	Date:

I have been made aware of my financial obligations to Foot & Ankle Center of Florida LLC and realize that they will make every attempt to secure payment through my insurances or workers compensation claim. I understand that a referral is needed to seek Podiatric services and that is my obligation to get it prior to my appointment. I also understand that some podiatric services may not be covered by insurance and that I may be billed for them and will be responsible for them when provided. I will pay for collection services, attorney fees for Foot & Ankle Center of Florida LLC if they place my account in collections for failure to pay.

Patient Signature:	Date:

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FINANCIAL POLICIES

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, or your financial responsibility. The patient or responsible party is responsible for seeing that the entire bill is paid in full. Responsible parties will be responsible for any collection fees, interest, and other expenses necessary to collect on any account, including court costs, should legal action be necessary to collect.

We will ask to see your insurance card on your first visit and will scan your card into our system as needed to keep our information current. We will ask for this information at every visit, in order to ensure that no change in benefits or carrier has occurred. Will also scan and retain you driver's license for collection purposes. Please notify us if your insurance carrier or policy has changed. Billing of insurance is a courtesy we provide for patients and is not required by law.

PLEASE READ AND INITIAL EACH LINE BELOW ACKNOWLEDING YOU HAVE READ ALL POLICIES.

INTIAL HERE	POLICY
	COPAYMENTS: Your insurance **REQUIRES** that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit.
	DEDUCTIBLES AND CO-INSURANCE: We may collect your deductible and co-insurance at the time of service. FACFL will bill your insurance company. Patient Responsibility portions of your bill are to be paid within 90 days.
	SELF-PAY/UNINSURED: Self-pay accounts shall exist if a patient has no insurance coverage or no evidence of insurance coverage. For new patients, a payment of **$350.00** is required on the day of your appointment before being seen by the health care provider. If you are unable to pay the **$350.00** please contact the billing office prior to your appointment. A discount off regular fees is offered for payment made at time of service.
	REFERRALS: If your insurance plan requires a referral from your primary care physician it is your responsibility to obtain it prior to your appointment and to have it with you at the time of the appointment. If you do not have your referral, **YOU MAY BE REQUIRED TO RESCHEDULE.**
	RETURNED CHECK FEES: Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a **$50.00** fee per check returned.
	FORMS/PAPERWORK: There is a **$75.00 pre-payment** per form fee for the completion of paperwork or forms relating to disability, FMLA, etc. This fee is collected prior to completion of the paperwork, and for each time the paperwork is required. Allow seven working days for completion of forms. **Any forms needed within 48 hours from the time it was given to our staff will need to pre-pay an additional $50.00 rush fee.**
	DMV HANDICAP PARKING APPLICATIONS: There is a $25.00 fee for **ALL** DMV handicap parking applications.
	NO SHOW FEE: You will be charged a **$50.00 fee** if you fail to cancel your appointment with 24 hours of your scheduled appointment or do not show for your scheduled appointment.
	SURGERY CANCELATION FEE: Any surgeries cancelled within 7 business days of the scheduled surgery date will incur a **cancellation fee of $500.00. (Fee will be waived if surgery is canceled due to a death in the family, illness or if the patient is not cleared for surgery OR if our doctors determine a delay is needed.)**

Patient Signature/Responsible Party:	Date:
Patient Name if different from Responsible Party	Relationship to Party:

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Acknowledgement Section / Request:	
Patient statement: To the best of my knowledge, the information I will provide is accurate and complete. Under Penalty of Perjury under laws of State of Florida and the Federal Statutes by which we are governed.	
Patient Signature:	Date:
I would preferred to be reached by: ○ Home Phone ○ Cell Phone ○ Home Voice Mail. ○ Email:_____ ○ Our Patient Portal System May we leave messages on any of the above: ○ Yes ○ No	
Patient Signature:	Date:
PERSONS OR FAMILY MEMBERS THAT MY INFORMATION MAYBE RELEASED TO:	
NAME:	RELATIONSHIP:
NAME:	RELATIONSHIP:
NAME:	RELATIONSHIP:
Patient Signature:	Date:
CONSENT FOR TREATMENT	
I consent to and authorize the physician(s), physician assistant(s), nurse practitioner(s), resident physician(s), health care student(s) and/or clinical staff of Foot & Ankle Center of Florida or it's associates or affiliates or employees to provide diagnostic procedures and medical treatment including, but not limited to minor procedures and routine services deemed necessary at the time of the office visit, to me or the patient named on this form. I understand that the practice of medicine is not considered exact science and acknowledges that no guarantees have been made to the patient named on this form.	
Patient Signature/Responsible Party:	Date:
Patient Name if different from Responsible Party	Relationship to Party: