SOUTHWEST foot institute™

Foot & Ankle Specialists of Arizona

Sun City West Podiatry

REGISTRATION FORM

(Please Print)

Today's Date:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Street Address:	City:	State:	Zip Code:

Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	Preferred Contact Number: Home ☐ Cell ☐ Work ☐

Birth Date:	Age:	Sex: ☐ M ☐ F	E-mail address:

IN CASE OF EMERGENCY

Emergency Contact Person:	Relationship to Patient:	Home Phone #: ( )	Work Phone #: ( )

PHARMACY INFORMATION

Pharmacy Name: Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Insured Name:	Insured Birth Date:	Occupation:	Insured Employer:

Insured Employer Address:	Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Primary Insurance:	Group #:	Policy #:	Secondary Insurance Company:

Referred to Us by Whom:

☐ Dr. _____ ☐ Insurance Plan ☐ Hospital / Urgent Care ☐ Newspaper ☐ Family / Friend
☐ Website / Internet ☐ Close to Home/Work ☐ Other _____

Assignment, Release and Consent

I, the undersigned certify that I (or my dependent) have insurance coverage with the above named insurance company and assign directly to Foot & Ankle Specialists of Arizona (FAofAZ) all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize David F Jaffe DPM to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions including Medicare benefits for payment to be made payable to FAofAZ for any services. I authorize the use of a billing service to submit insurance claim(s) for treatment rendered at this office. Please be advised that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If you ever have any questions regarding your coverage and/or benefits,

please contact your insurance company. Although we do accept assignment of insurance benefits, we require payments of co-payments due at the time of service. If you have a deductible or coinsurance amounts to be met, you will be billed once your insurance has processed and paid their portion of the claim.

I certify that all information given is true and correct to the best of my knowledge. I give permission to FAofAZ to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my medical condition.

Patient/Guardian Signature: _____ Date: _____

Patient's name:	Height:	Weight:	Shoe Size:

Social History:	Tobacco? ☐ Never ☐ No ☐ Yes _____ Packs per day? For (how many) _____ years? ☐ Quit When?
	Alcohol? ☐ Never ☐ Rare ☐ Occasional ☐ Daily
Family History:	☐ Diabetes ☐ Heart Disease ☐ Cancer ☐ Unknown ☐ None ☐ Other

PRIMARY CARE PHYSICIAN **Check here if None** ☐

Doctor's Name: Date of last visit:	Phone # ( )

ALLERGIES **Check here if None** ☐

☐ Anesthetics ☐ Aspirin /Anti-Inflammatory Medications ☐ Codeine ☐ Demerol ☐ Iodine ☐ Metal (Nickel) ☐ Penicillin ☐ Sulfa ☐ Seafood ☐ Latex ☐ Tape ☐ Erythromycin ☐ Other: _____

REASON FOR EVALUATION / TREATMENT

Please briefly describe why you are here today. ☐ Left ☐ Right ☐ Both feet	How long?	Prior Treatment? ☐ Y ☐ N By Dr. _____

PAST SURGICAL HISTORY (please list surgeries below) **Check here if None** ☐

Surgeries:

CHECK ALL that apply either PAST or PRESENT **Check here if None** ☐

☐ Artificial Joints ☐ Artificial Valves ☐ Asthma ☐ Blood Clots ☐ Cancer (Type _____) ☐ Cholesterol Problems ☐ Circulation Problems in legs ☐ Dementia ☐ Depression / Anxiety ☐ Diabetes	☐ Fibromyalgia ☐ Glaucoma ☐ Gout ☐ Headaches ☐ Heart Problems (attack / chest pains/murmur /irregular beat/ congestive heart failure/ mitral valve prolapsed/ valve disease ☐ Hepatitis ☐ High Blood Pressure	☐ HIV / AIDS ☐ Kidney Problems (Stones/ infection /failure/dialysis) ☐ Liver Problems ☐ Lung Breathing Problems ☐ Neurological Disorders ☐ Osteoarthritis ☐ Osteoporosis ☐ Parkinson's Disease ☐ Peripheral Neuropathy	☐ Prostate Problems ☐ Psoriasis / Eczema ☐ Rheumatoid Arthritis ☐ Stomach / Intestine (Ulcer / acid reflux) ☐ Stroke ☐ Substance Abuse ☐ Thyroid Disease ☐ Ulcers (Diabetic) ☐ Varicose Veins

Other Medical History (Please List):

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Fever ☐ Chills ☐ Night Sweats ☐ Shortness of breath ☐ Chest Pain

Diabetic? ☐ Y ☐ N	Test Blood Sugars? ☐ Y ☐ N How Often?	Range? Low to High	A1C:

MEDICATIONS: If you have a completed list, please give to receptionist to copy.

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		

Patient/Guardian Signature	***Date***

Foot & Ankle Specialists of Arizona, PLLC
Sun City West Podiatry
Southwest Foot Institute

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Foot & Ankle Specialists of Arizona (FAofAZ) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have a right to review the Notice of Privacy Practices prior to signing this consent. FAofAZ reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to FAofAZ Privacy Officer at 18301 N 79th Ave. #F-168 Glendale, AZ 85308.

With this consent, FAofAZ may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, FAofAZ may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, FAofAZ may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that FAofAZ restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to FAofAZ the use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, FAofAZ may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Legal Guardian (if applicable)

FOOT & ANKLE SPECIALISTS OF ARIZONA
SUN CITY WEST PODIATRY
SOUTHWEST FOOT INSTITUTE

MEDICARE NON-COVERED SERVICE RELEASE FORM

(Waiver of Liability, Informed Consent)

I have been informed by Foot & Ankle Specialists of Arizona that the services shown on this release form **may be denied** by Medicare Part-B as **services not covered by Medicare.** These services and/or supplies have been determined as "medically unnecessary" or "not reasonable" by Medicare Standards under section 1862(a) of the Social Security Act. I agree to be fully responsible for payment of these services and/or supplies. I, also understand that **Medicare will NOT reimburse me or the physician** for these services and/or supplies. In addition, I understand that all covered "non-routine" or "medically necessary" foot care, is subject to a 60 day interval between successive visits. Should any scheduled or unscheduled office visit fail to meet or exceed the **60 day limit**, the denied Medicare claim will then become the responsibility of the patient. In these cases, the patient agrees to accept responsibility for payment.

The following services are **not** covered by Medicare.

- Orthotic Devices (Shoe Inserts) functional and accommodative
- Digital pads, splints, spacers
- Any other service that Medicare refuses to cover

Patient Name (Print):_____

Patient Signature:_____Date:_____

18301 N 79th Ave #F-168 Glendale, AZ 85308
TEL: 623-544-9090 FAX: 602-603-5666

Patient name:	Identification number:

Advance Beneficiary Notice of Noncoverage (ABN)

Name of Product	Reason Medicare May Not Pay	Estimated Cost

What You Need To Do Now:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the Product listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

☐ Option 1. I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN) . I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ Option 2. I want the D. _____ listed above, but DO NOT bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ Option 3. I don't want the D. _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800- MEDICARE .

Signing below means that you have received and understand this notice.

Signature:	Date:

Primary Care Physician (PCP): _____ Last PCP Visit: _____

Consent Form For In-Office Procedures

During your visit with your doctor today, as part of your treatment plan, he/she may recommend one of a variety of procedures that may reduce your symptoms and help treat the problem(s) for which you are being seen today. Procedures that your doctor routinely performs in-office that **you are consenting for** include, but may not be limited to:

Toenail Procedures: Trimming of toenails, removal of ingrown toenails, burning of the ingrown toenail matrix to prevent recurrence, laser treatment for dystrophic toenails and nail biopsies. If being treated with the laser for dystrophic/thick toenails, you consent to nail biopsies approximately 4-6 weeks apart to monitor the progress of the laser treatments.

Callus/Wart Procedures: trimming of calluses/corns/warts and treatment with silver nitrate or other chemicals or products to prevent recurrence, removal of foreign bodies; also ENFD (epidermal nerve fiber density) biopsies

Hammertoe Procedures: percutaneous tenotomies of toe tendons, open tenotomies of toe tendons.

Post-Surgical Care: removal of pins, stitches, and/or staples from surgical procedures that have previously been performed; debridement of wounds that may arise if surgical wounds dehisce

Injections: injections with anesthetics (lidocaine, Marcaine, etc), steroids (Kenalog, dexamethasone, etc), sclerosing alcohol, platelet-rich plasma (PRP), or amniotic fluid products. If getting a PRP injection, you also consent to the blood draw required to have the blood to produce the PRP.

Wound Care: debridement and/or placement of wound VAC of ulcerations of the foot and ankle and wound grafting with synthetic membranes or other wound care products.

After discussing your diagnoses with you, if your doctor recommends one of the above procedures, he/she will perform the procedure with your verbal consent, assuming that you have signed this consent form that discusses the risks of such procedures, which include, but are not limited to:

Risks of procedures include, **but are not limited to**: **infection, and / or inflammation of the operated areas, excessive swelling, significant pain**, excessive bleeding, delayed or non-healing of incision and / or operated areas, poor cosmesis, peripheral vascular complications (i.e.- phlebitis, superficial venous thrombosis, compartment syndrome, deep vein thrombosis or pulmonary embolism, or arterial embolism), skin necrosis / ulcer, transfer callus or lesion, toe deformities (such as floppy toe, stiff toe, short toe, elevated or floating toe, if applicable), loss of toe or limb, allergic reaction to the suture, implant, or implanted materials, adverse reaction to the anesthesia, **failure of procedure** or reoccurrence of the condition, **worsening of the condition** / disability, damage to adjacent nerves or vascular structures, other deformities may develop, and **repeated procedures or surgery may be needed to correct the current condition or new conditions**.

By signing below, I give my consent for any recommended in-office procedures and acknowledge the risks of such procedures.

Patient Signature: _____ **Date**: _____

Patient Name: _____