ARCADIA
Foot and Ankle
a partner of my aim

New Patient Information Form

Date: _____
Patients Name: _____**Birth Date**: _____ **Sex**: M____ F_____
Home Phone :(_____)_____**Cell**:(_____)_____**EmailAddress**:_____
Address:_____**City:**_____**Zip**:_____
Preferred Language:_____ **Married**:_____ **Divorced**:_____ **Widowed**:_____ **Single**:_____
Occupation: _____
Referral & Care Team Information: Who may we thank for referring you?_____
Primary Care Physician: _____ **Primary Care Physician Phone:** (____) _____
Pharmacy Name:_____ **Cross Streets**:_____ **City**:_____**Zip Code**:_____
Visit Coverage: ☐ Health Insurance ☐ Self-Pay ☐ Workers' Compensation

AUTHORIZED CONTACT & COMMUNICATION

Who may we speak with regarding your care?
Name: _____ **Relationship**: _____**Phone**: (_____) _____
Name: _____ **Relationship**: _____**Phone**: (_____) _____

This person may:

☐ Receive information regarding appointments and care
☐ Schedule, reschedule, or cancel appointments
☐ Contact our office on my behalf regarding my care

Emergency Contact

Name: _____ Relationship: _____Phone: (_____) _____

May we leave voicemail messages regarding appointments or test results? ☐ Yes ☐ No

Patient/Guardian Signature: _____ Date: _____

Assignment and Release: I certify that I, and or my dependent(s) have insurance coverage and assign all benefits directly to the office of ***Arcadia Foot and Ankle*.** I understand I will be responsible for any portion of the claim, which is denied or not covered by my insurance company. I authorize the release to my insurance carriers any information necessary to process this claim.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES:

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider. **Arcadia Foot & Ankle Partners with My AIM** participates in an organized health care arrangement consisting of the greater Phoenix metropolitan area hospitals as well as physicians who have medical staff privileges at one or more of these hospitals. Participants in this arrangement work together to improve the quality and efficiency of the delivery of health care to their patients. As a participant in this arrangement, we may share your PHI with other members of this arrangement for purposes of treatment, payment or health care operations of this organized health care arrangement.

Signed: Date:

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENTS DIRECTLY TO: **Arcadia Foot & Ankle Partners with My AIM**

I understand that I am financially responsible for any co-payments, deductibles, co-insurance, and all charges, which are not covered by my insurance. I understand that there will be a **$25.00** service charge on all returned checks. **I understand that verification of benefits is not a guarantee of payment.** (Insurance benefits are determined by your insurance company when the claim is received.) I understand that I will be responsible for any portion of the claim that is allowed by, but not covered by, my insurance company. Initial: ____ With the exception of Medicare, I understand that if I have secondary insurance, I am responsible for payment of my co-insurance at the time service is rendered. I understand that, upon request, I will be provided with all required documentation to collect reimbursement myself. I understand that I am responsible for all charges if it is determined that the insurance information I have provided is not correct

Delinquent accounts will be turned over to a collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days. In the event my account is turned over for collection, I will pay all reasonable collection, court and attorney costs at the time the account is considered delinquent.

Signature of Responsible Party Printed Name of Responsible Party Date

RELEASE AND REQUEST OF INFORMATION:I hereby authorize Arcadia Foot & Ankle to release or request any medical information or incidental information by my referring physician or any other physician who have been or may become involved in my care.

Signature of Responsible Party Printed Name of Responsible Party Date

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NEW PATIENT INFORMATION FORM

Patients Name: _____Birth Date: _____

REASON FOR TODAY'S VISIT

Please explain why you are here today. (Pain, fracture, injury, etc.)_____

_____

(Arcadia Foot & Ankle specializes in the diagnosis and treatment of foot and ankle conditions)

Have you had recent foot/ankle XRAYS? YES NO When? _____ Where?_____ SMIL SIMON MED
Have you seen any other doctor for this or any other foot/ankle problem? Which Doctor?_____

Do you grant permission for this office to retrieve records from your previous treating physician? ☐YES ☐NO

Past or Current Medical Conditions

☐Addiction to Alcohol	☐Arthritis (Rheumatoid)	☐Diabetes Type I or II	☐ Cholesterol
☐Addiction to Narcotic	☐Arthritis (Osteo)	☐GI Problems (ulcers, IBS, reflux)	☐Kidney Disorder
☐AIDS/HIV	☐Cancer	☐Heart Disease	☐Liver Disease
☐Anesthesia Problems	☐Chronic Pain	☐High Blood Pressure	☐Vascular Disease
☐Sleep Apnea	☐Asthma / COPD	☐DVT/Blood Clot	

Please list any other medical problems:_____

_____

Surgical History: (*Please list all surgical procedures you have had***)**

_____

_____

Please list all current medications:

(*Please include mg and how often*)

_____

_____

_____

Family History (*please select all that apply*)

	Mother	Father	Grandparent
Anesthesia Problems	☐	☐	☐
Arthritis (Rheumatoid)	☐	☐	☐
Arthritis (Osteo)	☐	☐	☐
Cancer	☐	☐	☐
DVT / Blood Clot	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Vascular Disease	☐	☐	☐

Allergies:

☐None ☐Latex
☐Iodine ☐Metals (rash or blister with jewelry)
☐Codeine ☐Local Anesthetics
☐Sulfa ☐Penicillin

Please list any other allergies:

_____

Social History:

Tobacco Use	☐Yes	☐No	How Much _____
			How Long _____
Alcohol Use	☐Yes	☐No	How Often _____
Rec. Drugs	☐Yes	☐No	Which drugs _____
Currently Pregnant	☐Yes	☐No	Due Date

_____

Height:_____ Weight: _____ Shoe size:_____

PATIENT NO-SHOW POLICY

We understand that unexpected circumstances can happen. However, missed appointments affect our ability to provide timely care to all of our patients.

Please make every effort to attend your scheduled appointments or notify our office as soon as possible if you need to cancel or reschedule.

Our No-Show Policy

First No-Show:
You will receive a **warning**. The $50 no-show fee will be waived for your first missed appointment.

Second No-Show:
A **$50 no-show fee** will apply.

Third No-Show:
After **three no-show appointments, you may be discharged from our practice as a patient.**

Patients who repeatedly miss appointments may be subject to discharge from the practice regardless of whether previous fees were paid.

Please Help Us Avoid Missed Appointments

If you are unable to attend your appointment, please contact our office as soon as possible to cancel or reschedule.

Thank you for helping us provide the best possible care to all of our patients.

Patient Name: _____

Patient Signature: _____

Date: _____