FOOT ANKLE
SPECIALISTS OF AMES

Patient Name: _____ Date of Birth: _____
SSN: _____
Address: _____
City and State: _____
Zip: _____

Communication preferences:
I agree and consent to releasing information to me in the following manners:

	Phone Number	Preferred (X)	Detailed Msg. (X)
Home			
Work			
Cell			

Email Address: _____

Preferred method of communication:

Phone: ☐ Patient Portal: ☐ Mail: ☐

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

I give Foot & Ankle Specialists of Ames permission to disclose medical, financial or insurance information to the designated people listed below.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

By signing this form, you acknowledge that Foot & Ankle specialists may use and disclose Protected health information(PHI) about you for treatment, payment and healthcare operations. You have the right to restrict how PHI is used or disclosed for treatment, payment or healthcare operations.

Print Patient Name_____ **Signature**_____
Date_____

If patient is under 18 please complete the following:

Print Name_____ **Signature**_____

Relationship to Patient_____

Please complete 2nd page ➡

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Patient Acknowledgement and Authorization Form

HIPAA:

- Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of our protected health information. Foot &Ankle Specialists will provide you with a copy of Notice of Privacy Practices (NPP) for more complete description at your request.
- Foot & Ankle Specialists of Ames reserve the right to change the terms of its NPP at any time.

Assignment of Benefits:

- I certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Foot & Ankle Specialists of Ames all insurance benefits, payable to me for services rendered.
- I understand that I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees **at the time of service**.
- I authorize the release of medical record information to my insurance company third party payor or requested physician to provide continuity of care.
- I authorize the use of this signature on all insurance submissions.

Authorization of Treatment:

- I hereby give my permission to the doctor at Foot & Ankle Specialists of Ames to perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in diagnosis and/or treatment of my feet and/or Ankles.

This authorization form will remain in effect for 1 year from the signature date. I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and acknowledge that I have received a copy of Foot & Ankle Specialist of Ames Notice of Privacy Practices and understand and accept its terms.

Print Patient Name_____ **Signature**_____

Date_____

If patient is under 18 please complete the following:

Print Name_____ **Signature**_____

Relationship to Patient_____

Medicare Secondary Payer Questionnaire: (MUST be completed by patient's that present with Medicare products)

1. Do you have any group health insurance coverage based upon your current or former employment?
   Yes No
2. Do you have any group health insurance coverage based upon your spouse or other family member's employment? Yes No
3. Are you receiving any of the following benefits? ● Black Lung: Yes No
   ● Veterans Administration: Yes No ● End Stage Renal Disease: Yes No
4. Is this service related to: Automobile injury or illness? Yes No
   Work-related injury or illness? Yes No
   Any other third-party liability injury or illness? Yes No

If you have answered yes to any of the above questions, we will request further benefit information.