FOOT ANKLE
SPECIALISTS OF AMES

PATIENT INFORMATION

First Name: _____ MI:_____ Last Name: _____

Date of Birth: _____ Sex: □ M □ F Social Security Number:_____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ □ (Preferred) Cell Phone: _____ □ (Preferred)

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Other Spouse Name: _____

Power of Attorney: □ Yes □ No Email:_____

Communication preferences: □ Phone Call □ Text (Appt only) □ Patient Portal □ Message may be left

Insurance Information:

Primary Insurance:_____ ID#_____ Group#_____

Primary Policy Holder: □ Self □ Spouse □ Parent □ Other: _____

Policy Holder Name:_____ DOB:_____ SSN: xxx-xx-_____

Secondary Insurance:_____ ID#_____ Group#_____

Secondary Policy Holder: □ Self □ Spouse □ Parent □ Other: _____

Policy Holder Name:_____ DOB:_____ SSN: xxx-xx-_____

Emergency Contact(s):

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

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

FOOT ANKLE
SPECIALISTS OF AMES

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.**