JEFF L. HARSCH, D.P.M., F.A.C.F.A.S.
DIPLOMATE, AMERICAN BOARD OF FOOT AND ANKLE SURGERY
FELLOW, AMERICAN COLLEGE OF FOOT AND ANKLE SURGEONS

PATIENT REGISTRATION

Date:_____

Name:_____M.I_____ Preferred Name:_____

Mailing Address:_____
Number Street Apt#

_____
City State Zip Code

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____

Date of Birth: _____/_____/_____ SS#:_____-_____-_____ Marital Status:_____ Gender:_____

Employer/School: _____ □ Full Time □ Part Time □ Retired

If a minor, please designate the financially responsible party:

Name:_____ SS#:_____-_____-_____DOB:_____/_____/_____

May we discuss your medical condition with another person? □ Yes □ No

If yes, whom:_____ Relationship:_____

May we leave a voicemail pertaining to your care? If yes, please provide the phone number:_____

Whom may we thank for referring you? _____

Primary Care Physician:_____ Phone:_____

Pharmacy Name:_____ Pharmacy Location:_____

Emergency Contact:

Name:_____ Relationship:_____ Phone:_____

Primary Insurance:_____

Member ID:_____

Group #:_____

Subscriber Name:_____

DOB: _____/_____/_____ SS#:_____-_____-_____

Secondary Insurance:_____

Member ID:_____

Group #:_____

Subscriber Name:_____

DOB: _____/_____/_____ SS#:_____-_____-_____

CONSENTS

Acknowledgement of Privacy Practices (HIPPA)

Your office has my permission to use my health care information for the purpose of obtaining payment for services, to determine insurance benefits, and for any other purpose set out in our privacy practices. It is a requirement by state law to offer a copy of our Notice of Privacy Practices to our patients. Should you like a copy of these practices, please request one. By signing below you agree and acknowledge our privacy practices.

_____

Patient Signature

Consent for History of Prescriptions (HIPPA)

Your office has my permission to utilize electronic prescription software to view and add to my medication list. I understand this will allow Dr. Harsch to electronically send accurate, error-free and understandable prescriptions directly to my pharmacy.

_____

Patient Signature

Rescheduling and No Show Policy

If you need to cancel or reschedule your appointment, we require you do so at least 24 hours before your scheduled appointment. We understand that emergencies do happen unexpectedly and will cause you to cancel or reschedule your appointment at short notice. Our policy is the first cancelled or rescheduled appointment will be forgiven, the second consecutive cancellation or rescheduled appointment will result in a $50 fine. If the appointment is missed all together without notice, you will be charged the $50 fine.

_____

Patient Signature

Insurance Verification, Authorization and Payment

Our office will verify and bill your insurance as a courtesy to you. It is patient responsibility to insure we are in network with your insurance and that no referral is required for reimbursement purposes. We will **not** be involved with any disputes regarding authorizations or insurance coverage. We are specifically told from each insurance company that the benefits quoted are not a guarantee of payment. We strongly suggest you also call your insurance company to verify your benefits and any out-of-pocket expenses you may be responsible for. You are ultimately responsible for all charges incurred, regardless of potential insurance benefits.

_____ _____

Patient Signature Date

FINANCIAL POLICY FOR MEDICAL SERVICES

We ask that you present your insurance card at your initial visit and any time there is a change made to your insurance policy. There is always a chance the patient will be financially responsible for all services rendered at the Foot and Ankle Clinic. For example, if we are not a participating provider within your insurance network, if you fail to provide your insurance card, or if you provide the incorrect insurance card. If we have a contract with your plan, we will file all claims with your insurance company.

Please note that even if a procedure is deemed medically necessary and is considered a covered benefit from your insurance company, there may be deductibles or coinsurance amounts due after the claim has been processed and paid by your insurance plan. Once the claim has been completed and paid by your insurance company, you will receive a statement for the remaining balance that you are financially responsible for. If you would like an itemized statement of your visit, please request one and it will be provided to you. We accept cash, checks, MasterCard, Visa, and Discover.

Co-Payment Policy

If there is a specialty copay with your insurance company, we will collect payment at the date those services are rendered. Should you fail to provide payment for your copay, you will be billed for that amount.

Self-Payment Policy

New patients are responsible for an initial office visit of $140-$200. If you are unable to pay for the remaining charges at this initial encounter, the remainder of payable services can be billed to you once a payment plan has been established in office. Payment for the office visit is required each time services are rendered. This is applicable for patients without available insurance information and patients with out-of-network insurance.

Outstanding Balances

A statement will be mailed at the beginning of each month. If no payment has been received within 3 months from the date of service, the remaining outstanding balance will be turned over to our collections company, Kansas Counselors, Inc. All collection fees and court costs will be added to your balance.

If a patient *refund* is due, the Foot and Ankle Clinic will issue a check once the following criteria have been met:

- You have not been seen in office for 30+ days
- There are no pending insurance claims on your account
- There are no outstanding patient balances on your account

The patient has read and understands the financial policy and agrees to the specified terms therein. This policy will stay in effect as long as you are a patient of the Foot and Ankle Clinic

_____ _____

Patient Signature Date

Preferred Name: _____

PATIENT HISTORY

Primary Care Physician:_____ Date Last Seen:_____

The reason for your appointment today:_____

Medical History:

□ AIDS/HIV
□ Alzheimer's Disease
□ Angina/Chest Pain
□ Anemia
□ Arthritis
□ Asthma
□ Bleeding Disorders
□ Cancer
□ Chronic Diarrhea
□ Type 1 Diabetes
□ Type 2 Diabetes
□ Dementia
□ Epilepsy
□ Ear Problems
□ Eye Problems
□ Fainting
□ Gout
□ Headaches
□ Heart Disease
□ Hemophilia
□ Hepatitis
□ High Blood Pressure
□ High Cholesterol
□ Kidney Disease
□ Pacemaker
□ Psychiatric Care
□ Respiratory Disease
□ Rheumatic Fever
□ Stroke
□ Tuberculosis
□ Valve Replacement
□ Joint Replacement
□ Unexplained Weight Loss
□ Other:_____

Family History:

□ Diabetes
□ Heart Disease
□ Cancer
□ Stroke

Previous Surgeries	Date Mo/Yr	Previous Hospitalizations	Date Mo/Yr

Medications	Dosage	Medications	Dosage

Allergies:

□ Adhesive Tape □ Aspirin □ Codeine □ Demerol □ Iodine □ Latex □ Local Anesthetics □ Penicillin □ Seafood □ Sulfa Drugs □ Other:_____ □ No Known Drug Allergies

Social History:

Nicotine Use: □ Yes □ No; If yes, how many cigarettes a day _____ Former Nicotine Use: □ Yes □ No

Alcohol Use: □ Yes □ No; If yes, how many drinks? _____ □ Daily □ Weekly □ Monthly □ Annually

Recreational Drug Use: □ Yes □ No; If yes, what type and frequency? _____