NY FOOT & ANKLE SPECIALISTS

PLEASE PRINT

PATIENT INFORMATION

FIRST NAME_________________________ **LAST NAME**_________________________

Address____

City_______________________ **State**______________ **Zip code**_______________

Phone # _______________________ **Email Address**___________________________

Date of birth ____________________ **Sex ☐F ☐M ☐Other Marital Status**______________

In-case of Emergency contact:

Name________________________________ **Phone #**______________________

Relation ship ____

++

Primary Insurance ___________________________ **ID #** ___________________________

Provider Services Phone #_____________________________

Name on Card_________________________________ **☐Self ☐Spouse ☐Dependent**

Secondary Insurance ___________________________ **ID #** ___________________________

Provider Services Phone #_____________________________

Name on Card_________________________________ **☐Self ☐Spouse ☐Dependent**

++

Medical Information:

Primary Care Physician____

Phone # ____

Pharmacy Name: _____________________________ **Phone #:**_______________________

Height______________**Weight**______________**Last Blood Sugar**__________ **Last A1C**________

List of Allergies: **LATEX Allergy: ☐YES ☐NO**

List of Medications:

Medical Conditions: ____

____

____

____

NY Foot & Ankle Specialists

CONSENTS

Patient Name____

I certify the information I have provided is correct and true to the best of my knowledge. I am responsible for providing accurate and updated information regarding my health, insurance benefits, address and phone number. I give consent to the Doctors at NY Foot & Ankle to administer and perform procedures deemed necessary in the diagnosis and treatment of my foot/ankle condition.

Signature____ Date_____________

Notice of Privacy Practices

By signing below, I acknowledge I have access to the HIPAA Policy. I may obtain a copy by requesting it at the front desk, and I may obtain a copy on the website NYFootAnkle.com

Signature____ Date_____________

Referrals

I acknowledge I am responsible for obtaining referrals from my Primary Care Physician. Failure to do so will result in claim denials. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE as a result of not obtaining referrals.**

Signature____ Date_____________

Medicare

I understand I am responsible for my yearly deductible, co-insurance and any NON-COVERED services. Deductible and co-insurance are determined by Medicare yearly. **My signature below will be used for assignment of benefits and release of information to NY Foot & Ankle.**

Signature____ Date_____________

Third Party Insurance

I certify that I have active coverage with insurance and **my signature below will be used for assignment of benefits and release of information to NY Foot & Ankle**. I will be responsible for any copayments, deductibles and any NON-COVERED services.

FOR ANY OUT OF NETWORK, I am responsible for the bill. This office will submit a bill to the insurance on my behalf.

Signature____ Date_____________

Authorization for release of information

My information may be released to my insurance company, pharmacy, or vendor for treatment purposes.
In addition, I authorize the person below to receive my medical information:

Name______________________________________ Relationship:____________________

Phone Number____

Signature____ Date_____________

NY FOOT & ANKLE SPECIALISTS

24 Hour Cancellation & NO SHOW Fee Policy

Recognizing that everyone's time is valuable, and the appointment time is limited, we ask that you provide a 24-hour notice if you are unable to keep your appointment. Each time a patient misses an appointment another patient is prevented form receiving care. Therefore, the Physicians of NY Foot & Ankle reserve the right to charge a fee of $35 for each missed appointment (No Show). The no show fee will be billed to the patient, is not covered by insurance, and must be paid prior to your next appointment. Multiple no shows in any 12-month period will result in termination from our practice.

Cancelling surgery **within 2 weeks of surgical date** without a compelling reason will result in a fee. It takes multiple parties to co-ordinate your surgery, your insurance authorization is time sensitive and will need to be updated. It also prevents another patient from having surgery.

Signature____ Date________________

Bounced check fee

I understand if my check bounces that I will be responsible for any bank fees and an additional fee of $35.

Signature____ Date________________