Hoosier Foot and Ankle

Get your foot in the door and we'll do the rest!

Dear Patient,

Welcome to Hoosier Foot & Ankle. You have made an excellent choice for your podiatric needs. It is our hope that this pre-visit information will save you time at your first visit.

Please complete the enclosed Registration/Patient Information form and bring it, along with all attached documents in this packet, with you to your appointment at Hoosier Foot & Ankle. If you are unable to keep this appointment, please call the office at 317-346-7722 at least 24 hours in advance.

Hoosier Foot & Ankle currently participates with several insurance plans, including Medicare and Medicaid. If you are unsure if we accept your specific insurance plan, please contact our office at the number above. Also, please contact your insurance company **prior** to your visit to make sure the services rendered will be covered and to obtain your benefit information. **Remember to bring your insurance card and your photo ID with you to your appointment.** If you do not have your insurance card(s) or identification, you will be asked to pay cash for the visit, or to reschedule.

Our office staff will contact your insurance company prior to your visit to verify benefits and obtain deductible and copayment amounts. All insurance verifications provided to us state that "**this verification is NOT a guarantee of payment"**. It is your responsibility to know and understand your individual health benefits. All co-payments will be collected before services are provided.

Even though we accept your insurance, we may require payment toward the balance of your visit to cover outstanding deductibles and non-covered services.

If you are being seen for a work-related injury, please bring your employer's proof of coverage and workers compensation required forms.

If you do not have insurance, you will be set up on a cash account basis and full payment will be required at the time of visit.

Thank you for choosing Hoosier Foot and Ankle. We look forward to meeting you and taking care of your foot care needs.

The Staff at Hoosier Foot and Ankle

Hoosier Foot and Ankle

NEW PATIENT REGISTRATION

(PLEASE PRINT)

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MI:	DOB:
ADDRESS:	CITY:	STATE:	ZIPCODE:
HOME PHONE:	CELL PHONE:		
SSN#:	EMAIL:		

RACE:
- O American Indian or Alaskan Native
- O Native Hawaiian or Pacific Islander
- O Black or African
- O Caucasian

PREFERRED LANGUAGE:

ETHNICITY: O Hispanic/Latino O Not Hispanic/Latino

EMPLOYER: PHONE:

RESPONSIBLE PARTY/INSURANCE CARRIER

INSURANCE CARRIER:	POLICY #:	GROUP #:	
POLICY HOLDER'S NAME:	DOB:	SSN #:	M/F

SECONDARY INSURANCE

INSURANCE CARRIER:	POLICY #:	GROUP #:	
POLICY HOLDER'S NAME:	DOB:	SSN #:	M/F

EMERGENCY CONTACT

NAME:	RELATIONSHIP TO PATIENT:	
HOME PHONE:	CELL PHONE:	WORK PHONE:

- O EMERGENCY CONTACT
- O LEGAL GUARDIAN
- O PRIMARY CONTACT
- O RELEASE OF MEDICAL RECORDS
- O RESIDES WITH
- O PRIMARY CAREGIVER

PRIMARY CARE DOCTOR:	PHONE:
REFERRAL SOURCE: INTERNET/CURRENT PATIENT/PHYSICIAN/HFA EMPLOYEE/OTHER (PLEASE CIRCLE)	
NAME OF PERSON REFERRING:	
WEBSITE:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Hoosier Foot& Ankle or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date

PATIENT HISTORY

TOBACCO USE:

O Currently Smoke: Packs Per Day:
O Former Smoker Quit Date:
O Never Smoked
O Smokeless Tobacco

ALCOHOL USE:

O Heavy O Never
O Moderate
O Occasionally
O Former User

RECREATIONAL DRUG USE:

O Currently User
O Former User
O Never

Height:
Weight:
Shoe Size:
Shoe Style:

Marital Status: O Single O Married O Divorced O Widowed

FAMILY HISTORY: (please circle all that applies)

M/F Alcoholism
M/F Anesthesia Complications
M/F Arthritis
M/F Cancer
M/F Diabetes
M/F Disorder of the Respiratory System
M/F Heart Disease
M/F Neurological Disorder
M/F Siezure Disorder

PATIENT ILLNESSES: (please check all that apply)

O Alcoholism
O Allergic Rhinitis
O Amputation
O Anemia
O Anxiety
O Arthritis
O Asthma
O Bleeding Disorder
O Cancer
O Cellulitis
O COPD
O Cystic Fibrosis
O Depression
O Diabetes
O Diverticulitis
O Ear Problems
O Fungal Infections
O GERD
O Glaucoma
O Gout
O Hearing Loss
O HIV/AIDS
O High Cholesterol
O High Blood Pressure
O Hyperthyroidism
O Hypoglycemia
O Hypothyroidism
O Ingrown Toenail
O Keratosis
O Kidney Disease
O Liver Disease
O Low Blood Pressure
O Menopause
O Migraines/Headaches
O Multiple Sclerosis
O Murmur
O Mycosis
O Narcolepsy
O Nasal Sinus Problems
O Nerve Injury
O Neurological Disorder
O Neuropathy
O Obesity
O Osteoarthritis
O Osteoporosis
O Pancreatic Disorder
O Parenthesis
O Parkinson's Disease
O Peripheral Vascular Disease
O Pneumonia
O Psoriasis
O Restless Leg Syndrome
O Sarcoidosis
O Seizure Disorder
O STD
O Skin Discoloration
O Sleep Apnea
O Stomach Problems
O Stoke
O Thyroid Disease
O Tremor
O Tuberculosis
O Ulcers
O Urinary Incontinence
O Varicose Veins
O Warts
O Congestive Heart Failure
O General Cardiovascular Problems
O Lung/Respiratory Problems

OPERATIONS

Please List All Surgeries, Dates And Facility

Surgery	Date/Facility

ALLERGIES

Medical Allergies	Reaction
Are you allergic to Betadine? Y/N	
Are you allergic to Latex? Y/N	
Have you ever had complications with anesthesia?	

Medications

Medication Name	Dosage
Pharmacy Name:	
Pharmacy Address:	
Pharmacy Phone:	

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- O Spouse
- O Child
- O Other _____
- O Information is not to be released

The ***Release of Information*** will remain in effect until terminated by me in writing.

MESSAGES

Please call:

- O my home
- O my work
- O my cell

You may:

- O leave detailed message
- O leave message with spouse/child/parent
- O leave message asking me to return your call
- O _____

Signed: _____ Date: _____

Relationship to Patient: _____

Witness: _____ Date: _____

Notice to Medicare Beneficiaries about Coverage for Foot Care and Services

Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits. When you receive foot care services and items that are not covered Medicare benefits, you must pay for them personally or through any other insurance that you may have.

The purpose of this advance notice is to help you make an informed choice about whether or not you want to receive these foot care services or items, knowing that you will have to pay for them yourself. We do not send claims to Medicare for foot care services or items that are excluded from Medicare coverage.

Before you make a decision, you should read this entire notice carefully.

- The Medicare program does not cover most routine foot care and flat foot care. The Medicare law clearly excludes coverage for services in connection with "the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care." The Medicare law clearly excludes coverage for services in connection with "treatment of flat foot conditions and the prescription of supportive devices thereof" or with "the treatment of subluxations of the foot." Providers may not be required to submit Medicare claims for such services.
  NOTE: A narrow exception permits coverage of some foot care services when certain conditions result in severe circulatory problems or areas of diminished sensation.
- The Medicare program does not cover most orthopedic shoes or other foot support (orthotics). The Medicare law clearly excludes coverage for services in connection with "orthopedic shoes or other supportive devices for the feet."
  NOTE: A narrow exception permits coverage of special shoes and inserts for certain patients with diabetes.

This means that Medicare will not pay for most routine foot care, flat foot care, orthopedic shoes, or orthotics, because they are not Medicare covered benefits. Payment for these excluded foot care services and items is your responsibility.

If you have any additional questions concerning Medicare coverage for foot care services or items, you can contact Medicare at 1-800-MEDICARE (1-800-633-4227).

This notice is published by: American Podiatric Medical Association (APMA), P.O. Box 9312 Georgetown Road, Bethesda, MD 20814-1621. The Centers for Medicare & Medicaid Services has reviewed this APMA notice about foot care coverage and confirmed the accuracy of its content. This notice is only a general summary of foot care exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.

Medicare Beneficiary Signature: _____ Date: _____

Medicare/Medicaid Authorization - Assignment Agreement for Payments

Please place your initials beside each line indicating that you understand and will abide by the following:

____ I authorize Hoosier Foot & Ankle to furnish Medicare Part B or Medicaid with all the necessary information concerning diagnosis and treatment for my dependent or myself.

____ I assign to Hoosier Foot & Ankle the medical and/or surgical benefits to which my dependent or I are entitled under Medicare Part B or Medicaid.

____ After all efforts have been made to collect payment from Medicare Part B and any secondary insurance carriers, I agree to pay the balance of my bill within 30 days; I understand that if my balance is outstanding beyond 60 days, a 20% collection fee will be added to my balance. If that balance goes beyond 150 days, legal action may be taken. All legal fees will be applied to my unpaid balance. (This does not apply to patients covered by Public Assistance.)

____ I understand that payment plans are accepted only in certain circumstances, which must be discussed in advance with the office manager or doctor. If I cannot pay the co-insurance amount due, I will have to complete a financial hardship form which will be added to my medical record.

____ I may request a financial estimate prior to any treatment.

____ I understand that some services require a prepaid deposit. I agree to pay deposits when necessary.

_____ _____

Patient Name Date

_____ _____

Signature of Patient/Responsible Party Date

Please thoroughly read each Hoosier Foot and Ankle, LLC Policy, initial next to each policy and sign below:

Treatment Agreement

____ I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

Release of Information

____ For the purpose of payment, I allow ***Hoosier Foot and Ankle, LLC*** to release my Private Health Information to any and all of my insurance carriers, their third party payers and claim reviewers, until the claim is resolved. For the purpose of treatment, I also allow the above listed practice to release my information or contact any and all of my treating physicians.

Acknowledgement of Receipt of Notice of Privacy Practices

____ I acknowledge that I was provided a copy of the HIPAA Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice. The Hoosier Foot and Ankle, LLC HIPAA rights are also posted in lobby and at www.hoosierfootandankle.com.

Patient Financial Policy

____ You must provide personal (address, phone numbers, email address, etc) and/or insurance changes (carriers, networks, id numbers, etc) to the office at least 2 days prior to your appointment. In the event the office is not informed, you will be responsible for any charges denied.

____ You are responsible for all authorizations/referrals/pre-certifications needed to seek treatment with Hoosier Foot and Ankle, LLC physicians.

____ Your portion of payment for ALL office services is due **at the time of service**. We will accept VISA, MasterCard, Discover, cash or personal check.

____ Your insurance policy is a contract between you and your insurance company. **As a courtesy**, we will file your insurance claim for you with an assignment of benefits. You are agreeing to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, the patient or guardian seeking care for a minor, will be responsible for payment of services. You are encouraged to contact your designated patient account representative at our office with any questions.

____ Please honor our 24 reschedule/cancellation notice. Repetitive broken or cancelled appoints and/or non-compliance may result in a discharge from Hoosier Foot and Ankle, LLC offices. Any appointment where a language or hearing interpreter is requested a 48 hour notice of reschedule or cancellation will be required. If proper notice is not provided the patient will be billed any fees incurred for this service that is not utilized by that patient.

____ We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and **will require you to pay the co-pay/co-insurance/deductible at the time of service.** Your upfront portion will be calculated based on your insurance benefit/limits and our negotiated fee agreement with your carrier. If you are seeing our doctors on an 'Out of Network" basis, you will be subject to out of network rates.

____ Not all services are a “covered” benefit in all insurance policies; some plans even impose a waiting period before covering services. In the event your health plan determines a service to be "not covered/pre-existing," or you do not have an authorization, **you** will be responsible for all charges. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

____ Our office will file with secondary and tertiary insurances. For all other insurances, we will provide an itemized statement upon your request. If you possess two or three insurance plans, you MUST notify us of your designated PRIMARY and SECONDARY policy holder.

____ Pre-scheduled Surgical procedures require pre-payment/estimated deposit. Your deductible/co-insurance/co-pay for this procedure is due at the pre-operative appointment. For other services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

____ We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Any payment exceptions must be agreed upon in writing.

____ I understand that I am responsible for any outstanding balance remaining after insurance remittance has been received. A collection fee of 20% will be applied to outstanding balances past 60 days. Any balance not paid after 150 days may be referred to an attorney or collection agency. You agree to be responsible for all charges incurred including but not limited to interest allowed at the current legal rate, collection agency fees, reasonable attorney fees and court costs.

____ Accounts no longer maintaining a financial “Good Faith” status will result in the termination of the Hoosier Foot and Ankle, LLC and patient relationship.

____ There is a service fee of $25.00 for all returned checks. Upon an NSF or CLOSED ACCOUNT occurrence, all future remittances will need to be in other forms of payment. Restitution of NSF or any other reason will be filed with the local authority for collection and fines.

____ **Hoosier Foot and Ankle, LLC** will attempt to issue patient refund checks, if applicable, within 90 days of a completed investigation of the potential overpayment.

____ ONLY UNWORN and NON-custom items are returnable within 3 days of receipt. Custom items are NON-RETURNABLE.

____ In the case of divorced parents, payment is expected from the person signing this document and will be considered the guarantor for all payments for any services provided. Hoosier Foot & Ankle will not recognize any divorce decrees regarding reimbursement for medical services for any minor child of divorced parents.

____ College students with health insurance under their parent’s name will not be treated by any physician from Hoosier Foot & Ankle without written permission from parent or guardian. Original signature or fax is allowable.

Authorization of Payment

____ I hereby assign all Medical benefits directly to ***Hoosier Foot and Ankle, LLC*** for the payment of any services rendered. I also authorize release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay for the services I received, I will be financially responsible for payment.

We are dedicated to providing the best possible care and service to you and require your complete understanding of our policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

Patient's Name: _____ Signature of Patient/Guardian: _____

Date: _____

Office Witness: _____ Date: _____ _____ Patient initials to indicate copy received

HIPAA Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review this notice carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to provide this notice about our privacy practices, our legal duties and your rights concerning your health information. This notice takes effect on [date] and remains in effect until replaced.

We reserve the right to change our privacy practices and the terms of this notice at any time as applicable law permits. Any changes made effect all health information we maintain, including health information created or received before the change went into effect. Any changes will be reflected in this notice and the revised notice will be made available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for a variety of reasons. Typical situations are described below.

Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Communications: We may send appointment reminder postcards or leave voice mail messages reminding you of appointments or changes in appointments. We will use the phone numbers and address provided by you to send these communications. We may also have a sign-in sheet at the front desk of our office, where all patients sign in upon arrival.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any prior disclosures permitted by your authorization while it was in effect.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to help locate you and determine your general health condition; we may also use of disclose information to help identify and/or locate a family member, personal representative or other person responsible for your care. If you are available and competent, you will be contacted for permission before the information

is disclosed. If you are incapacitated or in an emergency situation, we will determine the need for disclosure based on our professional judgment.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we have reason to believe that you are a possible victim of abuse, neglect, domestic violence or other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information required for lawful intelligence, counterintelligence and other national security activities to authorized federal officials. We may disclose protected health information to correctional institution or law enforcement officials who have lawful custody of a patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at and receive copies of your health information, with limited exceptions. Requests must be submitted in writing; send a letter or complete a request form provided by the practice. We may charge you a reasonable fee for staff time and materials; charges will vary depending on the details of your request. You may be charged per page or per hour of staff time for copying records, and for postage for mailing records to you or another provider. Additional charges may be incurred for requests for health information summaries, or providing records in alternative formats. Every effort will be made to honor requests unless we cannot practically do so. Contact the office for a complete explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances when we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities. Records of this information are available from (date) onward. Reports are limited to six years of activity. One report request per year is complimentary; if you request this report more than once in a 12 month period, we may charge you a reasonable fee.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. Additional restriction requests must be submitted in writing. We are not required to agree to these additional restrictions. If we do, we will agree to them in writing.

Alternative Communication: You have the right to request that we communicate with you by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or locations, and provide satisfactory explanation of how payments will be handled under the alternative circumstances.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice via our Web site or by electronic mail (e-mail), you are also entitled to request a notice in hard-copy format. Contact the office to receive a hard copy.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact the practice privacy officer (see below). If you are concerned that we may have violated your privacy rights, you disagree with a decision we made about access to your health information, or you are unhappy with our response to a request you made about your privacy rights, please submit your concerns in writing to the office. You may also submit a written complaint to the US Department of Health and Human Services; we will provide contact information upon request. We support your right to health information privacy and will not retaliate in any way if you choose to file a complaint with us or the US Department of Health and Human Services.

Privacy Officer: **Missy Luttrell**
Telephone: **317-346-7722**
E-Mail: **mkluttrell@hotmail.com**
Address: **1159 W. Jefferson St, Suite 204, Franklin, IN 46131**

Acknowledgment of Receipt of Notice of Privacy Practices

Note: You are not required to sign this form.

I, _____, have received a copy of this office's notice of privacy practices.

_____

Signature

_____

Date

For office use only

We attempted to obtain written acknowledgment of receipt of our notice of privacy practices, but acknowledgment could not be obtained because (check all that apply):

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgment

____ An emergency situation prevented us from obtaining acknowledgment

____ Other (please specify below)

_____

_____

Office personnel signature: _____ Date: _____