Registration Form

Family Foot & Ankle Clinic

Dr. Joel Tikalsky, Dr. Mark Thomas, Dr. Anton Sella

5403 Normandy Street
Weston, WI 54476
715.241.8100

117 Main Street
Marathon, WI 54448
715.443.3300

438 Edison Street
Antigo, WI 54409
715.623.4200

Patient Information

Patient Name (Last, First, MI)

_____

Address_____

City, State, Zip _____

Email _____

Home Phone_____

Cell Phone _____

Birthdate _____ Age _____

Social Security Number _____

Sex _____ Marital Status _____

Employer/School _____

(Circle) Full-time Part-time Retired Unemployed

Work Phone _____

In case of emergency, contact:

Name _____

Relationship _____ Phone _____

Podiatric History

What is the chief complaint for which you came to be treated? Include foot, ankle, knee, thigh and hip complaints.

_____

_____

On a scale of 1-10 rate your pain;1 being minimal & 10 being extreme pain:

1 2 3 4 5 6 7 8 9 10

Have you ever been to a podiatrist before?

☐ Yes, Name _____ ☐ No

Last Visit _____

Indicate which foot problems you have now or have had in the past. (Please circle)

Ankle Pain	Heel Pain
Athlete's Foot	Ingrown Toenails
Bunions	Neuropathy
Corns & Calluses	Numbness in Feet or Legs
Flat Feet	Plantar Warts
Foot or Leg Cramps	Swelling in Ankles or Feet
Gout	Tired Feet

Height: _____ Weight: _____ Shoe Size: _____

Referred by _____ Date Seen_____

Treatment Consent

I hereby consent and give my permission to the doctor (and the doctor's assistant or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____ _____

Print name of Parent, Guardian or Personal Representative **Relationship to Patient**

Insurance Information

Subscriber Name _____

Relationship to Patient _____

Subscriber DOB_____ SSN _____

Insurance Company _____

Group _____

Subscriber ID _____

Secondary Insurance

Subscriber Name _____

Relationship to Patient _____

Subscriber DOB_____ SSN _____

Insurance Company _____

Group _____

Subscriber ID _____

Insurance Assignment and release

I certify that I have insurance coverage with the above insurance company(ies) and assign directly to the Family Foot & Ankle Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. FFAC may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Medicare/Medigap Authorization

I request that payment of authorized Medicare/Medigap benefits be made on my behalf to Family Foot and Ankle Clinic LLC for any services furnished to me by their providers. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the centers for Medicare and Medicaid services, my Medigap insurer, and their agent, any information needed to determine these benefits or benefits for related services.

Signature _____

Date _____ **Relationship to Beneficiary** _____

Family History:

Diabetes: ☐Yes ☐No Heart Disease: ☐Yes ☐No High Blood Pressure: ☐Yes ☐No
Cancer: ☐Yes ☐No Stroke: ☐Yes ☐No Arthritis: ☐Yes ☐No

Medical History

AIDS/HIV	___Yes	___No	Ear problems	___Yes	___No	Radiation treatment	___Yes	___No
Allergies to anesthetics	___Yes	___No	Epilepsy	___Yes	___No	Rash	___Yes	___No
Allergies to medicine/ drugs	___Yes	___No	Eye problems	___Yes	___No	Respiratory disease	___Yes	___No
Anemia	___Yes	___No	Fainting	___Yes	___No	Rheumatic fever	___Yes	___No
Angina	___Yes	___No	Headaches	___Yes	___No	Shortness of breath	___Yes	___No
Arthritis	___Yes	___No	Heart disease	___Yes	___No	Sinus problems	___Yes	___No
Artificial heart valves/joints	___Yes	___No	Hemophilia	___Yes	___No	Special diet	___Yes	___No
Asthma	___Yes	___No	Hepatitis/jaundice	___Yes	___No	Stroke	___Yes	___No
Back problems	___Yes	___No	High blood pressure	___Yes	___No	Swollen neck glands	___Yes	___No
Bleeding disorders	___Yes	___No	Kidney problems	___Yes	___No	Thyroid disease	___Yes	___No
Cancer	___Yes	___No	Liver disease	___Yes	___No	Tuberculosis	___Yes	___No
Chemical dependency	___Yes	___No	Low blood pressure	___Yes	___No	Ulcers	___Yes	___No
Chest pain	___Yes	___No	Nervous problems	___Yes	___No	Varicose veins	___Yes	___No
Chronic diarrhea	___Yes	___No	Phlebitis	___Yes	___No	Venereal disease	___Yes	___No
Circulatory problems	___Yes	___No	Psychiatric care	___Yes	___No	Unexplained weight loss	___Yes	___No
Diabetes	___Yes	___No						

Type 1___ Type 2___

Family Physician: _____ **Date of last visit**: _____

Alcohol Consumption: ☐No ☐Yes ☐Rarely ☐Occasionally ☐Socially ☐Moderately
Have you every smoked: ☐Never ☐Currently ☐Previously smoked and quit - when did you quit?_____

Exercise/Athletic Activities:_____

Surgeries:

☐Foot –Right or Left _____
☐Hip
☐Hysterectomy
☐Gallbladder Removal
☐Bypass
☐Ankle-Right or Left_____
☐Back/Apine
☐Appendix Removal
☐Thyroid
☐Stent Replacement
☐Knee-Right or Left_____
☐Open Heart
☐Hernia
☐Tonsillectomy
☐Other:_____
_____

Hospitalizations:

☐Never
☐Only Related to Surgeries/Reason:_____

Medications & Dosages:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies:

☐ Seasonal Allergies ☐ No known drug allergies

Drug/substance:	**Reaction:**		
☐Adhesive/Tape	_____	☐Latex	_____
☐Aspirin	_____	☐Penicillin	_____
☐Codeine	_____	☐Sulfa	_____
☐Iodine	_____	☐Others:	_____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMOs and PPOs, managed care organizations, IPAs, Medicare/Medicaid, or other governmental or third party payers, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or payment thereof. Calls may be recorded for training purposes and quality assurance.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with the Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the finding. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak to the Office Manager to obtain additional information regarding any questions you may have concerning this notice or to receive a printed copy of this notice. This Notice of Privacy Practices is effective as of April 14, 2003.

Patient Signature_____ **Date**_____

List family/friends that we may discuss your medical/financial matters with:

	Name of Individual:	Relationship (spouse, daughter, son, friend, etc.)
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

PATIENT FINANCIAL POLICY

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

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Payments for office services are due at the time of service. We will accept VISA, MasterCard, Discover card, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the account within 90 days from your visit, we will have to look to you for payment. We do not determine payment of a claim- the insurance company does. Please contact your insurance company for any questions on any claims that have been submitted.
- 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 only require you to pay the co-pay, co-insurance, and/or deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and no not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have authorization, you will be responsible for the complete charge. 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.
- You must inform the office of all insurance charges and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the clinic or outside surgical facility, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures that we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Accounts are subject to an 18% finance charge if bill is not paid within 60 days of receiving your patient statement from Family Foot and Ankle Clinic, LLC.
- There is a service fee of $30.00 for all returned checks. Your insurance company does not cover this fee.
- We understand there are times when an appointment will be missed due to unforeseeable circumstances. However, for repeat no shows for office appointments or for time blocked out for surgical procedures, there will be a **$25** no show fee charged for each no show. Each no show prevents a potential patient from being seen in the office and this is not fair to our patients or to Dr. Tikalsky/Thomas. A 24-hour notice is requested.

I fully understand and agree to the above stated financial policy for Family Foot and Ankle Clinic. I also understand by signing this agreement that I am giving my authorization to facilitate payment by third parties for services rendered and to agencies/third parties which may be contracted to facilitate collection of any accounts which are past due. Due to contract language between physician and insurance company, I understand I am financially responsible for all charges deemed to be "non-covered benefits" by my insurance company even if the insurance's explanation of benefits state the procedure is a "non-covered benefit" and "patient is not responsible".

Signature_____ **Date**_____

Patient's initial to indicate copy received_____ **Witness**_____ **Date**_____