



DR. GARY PRANT

ARBOR FOOT HEALTH CENTER

WWW.ARBORFOOT.COM

FINANCIAL ARRANGEMENTS AND INSURANCE

We are committed to providing you with the best possible care. If you have insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, and Discover. We will be happy to process your insurance claim form for reimbursement. However, in order to do so, you must provide us with a copy of your insurance card. We also ask that you pay your portion at the time of service.

Returned checks and balances older than 90 days are subject to additional interest charges of 1.5% per month and professional collection procedures. We will gladly discuss your proposed treatment and answer questions relating to your insurance. You must realize, however, that:

- 1) Your insurance is a contract between YOU, YOUR EMPLOYER and the INSURANCE COMPANY. We are not a party to that contract.
- 2) Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% of "UCR". "UCR" is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area. .
- 3) Not all services are a covered benefit in all contracts. Some Insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as healthcare providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges, are your responsibilities from the date the services are rendered. 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 the management of your account.

Accounts on which no payment is received for three billing cycles (90 days delinquent) will be subject to our collection procedure which may include turning the account over to a professional collection agency.

If you have any questions about the above Information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

I understand the original of this document will be kept in my chart. I printed a copy for myself.

Patient/Parent's Signature _____ Date _____

Print Name _____

WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

First Name _____ Middle Initial _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (____) _____

Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (____) _____

Work Phone (____) _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ 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.

The above-named doctor 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. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____
Name of

_____ for any services furnished to me by that provider.
Doctor or Clinic

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 agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative

Please print name of Beneficiary, Guardian or Personal Representative

Date Relationship to Beneficiary

PODIATRIC HISTORY

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

Is there any personal or family history of diabetes?
 Yes No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

Athletic activities in which you participate (please list and indicate frequency)

Please indicate which foot problems you now have or have had in the past.

- Ankle Pain Yes No
- Athlete's Foot Yes No
- Bunions Yes No
- Corns and Calluses Yes No
- Cramps or Numbness in Feet or Legs Yes No
- Flat Feet Yes No
- Foot or Leg Cramps Yes No
- Heel Pain Yes No
- Ingrown Toenails Yes No
- Plantar Warts Yes No
- Swelling in Ankles or Feet Yes No
- Tired Feet Yes No

Have you ever been to a Podiatrist before?
 Yes No

If yes, please list.

Name _____

Last visit _____

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | |
|--|--|---|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Rash <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Medicine or Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Foot or Leg Cramps <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves or Joints <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling in Ankles, Feet <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis or Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Tired Feet <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Varicose Veins <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No | Neuropathy <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Phlebitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Ear Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Surgeries you have had _____

HEIGHT _____

Hospitalization other than for the surgeries listed _____

WEIGHT _____

Family physician _____

Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years?

Yes No

If yes, please explain _____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

Pharmacy Name(s) _____

Pharmacy Phone(s) (_____) _____

Do you take oral contraceptives? Yes No

ALLERGIES

- | | |
|--|--|
| <input type="checkbox"/> Adhesive/Tape | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Anticoagulant Therapy | <input type="checkbox"/> Novocaine |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Seafoods |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | |
| Other _____ | |

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants 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

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient