First Choice
Ankle & Foot Care Center, PLLC

Heiko B. Adams, DPM, FACFAS *#
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Podiatric Surgeons
*Diplomat, American Board of Podiatry Surgery
#Board Certified in Foot and Ankle Surgery

Office: (502) 633-FEET (3338) *Fax: (502) 633-2704
www.myfootcare.com

Dear Patient:

On behalf of the staff and myself, I would like to take this opportunity to thank you for selecting our office for your podiatry care and to say "Welcome" to our practice.

Our primary concern is the patient's overall health and comfort. We will make every effort to provide only the best professional care.

It is our hope that all visits will be prompt and pleasant so that in the future you will desire to increase our family of patients though recommendations. Since it may be more convenient for you to fill out the information sheets before coming to our office, we have enclosed them with this letter.

To assist us in you care, please bring:

1. **A list of any prescribed medications you are presently taking.**
2. **A list of all surgeries you have ever had with the approximate date of when they occurred.**
3. **A referral for the visit if your insurance requires one.**

****Your appointment may have to be rescheduled if you do not have the proper referral information.**

If at anytime you have questions we will do our best to answer them.

Thanks again for selecting us for you podiatry care.

Sincerely,

Heiko B. Adams, DPM
&
Benjamin Schneider, DPM

Shelbyville
1701 Midland Trail* Shelbyville, KY 40065

Frankfort
Frankfort Medical Pavilion
279 Kings Daughter Drive, Suite 203
Frankfort, KY 40601

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This is just a summary. You may request a copy of the complete Notice of Privacy Practices from the front office

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of students.

Uses and Disclosures Based on Your Authorization

Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization

In the following circumstances, we may disclose your health information without your authorization:

- To family members or close friends who are involved in your healthcare;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of audits, investigations, and other oversight activities;
- To Government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights

As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have to make of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concert or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

Patient History Form

Chief Complaint:

- ☐ Achilles Tendinitis
- ☐ Ankle Pain
- ☐ Ankle Injury
- ☐ Bump/Knot/Mass
- ☐ Bunion
- ☐ Burning Feet
- ☐ Callus
- ☐ Corn
- ☐ Crack/Fissure/Dry Skin
- ☐ Diabetic Foot Care
- ☐ Edema/Swollen foot,ankle, leg
- ☐ Foot Injury
- ☐ Gout Attack
- ☐ Hammertoe
- ☐ Heel Pain/Plantar fasciitis
- ☐ Ingrown Toenail
- ☐ Itching
- ☐ Laceration
- ☐ Leg Ulcer
- ☐ Nail fungus/Thick/discolored nails
- ☐ Neuritis
- ☐ Numbness
- ☐ Onychomycosis
- ☐ Plantar Fibroma
- ☐ Rash
- ☐ Sprained Ankle
- ☐ Tarsal Tunnel Syndrome
- ☐ Tendinitis
- ☐ Tenosynovitis
- ☐ Tinea Pedis/Athlete's Foot
- ☐ Ulcers
- ☐ Warts
- ☐ Wound

Allergies/Sensitivities

- ☐ NO KNOWN DRUG ALLERGIES
- ☐ Aspirin
- ☐ Adhesive Tape
- ☐ Latex
- ☐ Codeine
- ☐ Iodine
- ☐ Anesthetics
- ☐ Seafood
- ☐ Penicillin
- ☐ Peanuts
- ☐ Sulfa
- ☐ Other

Reaction Type: _____

_____

_____

Current Medications

☐ No Known Current Medication

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Surgical History & Year

- ☐ No Significant Past Surgical History
- ☐ Angioplasty _____
- ☐ Arthroscopy _____
- ☐ Back Surgery _____
- ☐ Hip Surgery _____
- ☐ Heart Surgery _____
- ☐ Ankle Surgery _____
- ☐ Foot Surgery _____
- ☐ Knee Surgery _____
- ☐ Cancer Surgery _____
- ☐ Hysterectomy _____
- ☐ Gallbladder Surgery _____
- ☐ Appendectomy _____

Please enter additional Surgical History details if any: _____

_____

Past Medical History

- ☐ No Significant Past Medical History
- ☐ Arthritis
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Degenerative Joint Disease
- ☐ Diabetes
- ☐ Gout
- ☐ High Blood Pressure
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Anemia
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleed Disorders
- ☐ Blood Clots
- ☐ Circulatory Problem
- ☐ Epilepsy
- ☐ Fainting/Dizziness
- ☐ Foot/Leg Cramps
- ☐ Hepatitis
- ☐ HIV
- ☐ Neurological Disorders
- ☐ Psychiatric Disorder
- ☐ Swelling of legs/ankle/feet
- ☐ Varicose Veins
- ☐ Dialysis
- ☐ Numbness/Neuropathy

Please enter additional Past Medical History details if any: _____

_____

Family History

List: Mother, Father, Sibling, Grandmother, Grandfather If Applicable

- ☐ No Known Family History _____
- ☐ Heart Disease _____
- ☐ Bunions _____
- ☐ Neurological Disorder _____
- ☐ Arthritis _____
- ☐ Stroke _____
- ☐ Hammertoe _____
- ☐ Bleeding Disorders _____
- ☐ Flat Feet _____
- ☐ Diabetes _____
- ☐ Circulation Problems _____

Please enter additional Family History details if any: _____

_____

Social History

Marital Status M D S W

Employment Type FT PT Retired Student

Smoking Status Heavy Light Previous Never

Do You Drink Alcohol? Y or N Beer Wine Other

Caffeine Intake Y or N If so, how much? _____

Does your lifestyle involve more time on your feet? Y or N

If yes, please describe _____

_____

_____

Signature: _____ Date: _____

Physician Signature: _____ Date: _____

PAPER WORK MUST BE COMPLETED & RETURNED TO OFFICE PRIOR TO NEXT APPOINTMENT

Personal Details:

Prefix: Mr. Mrs. Ms. Dr. Suffix: Jr. Sr. III

First Name:_____ Middle:_____ Last: _____

Birth Date: _____ Sex: M Or F Social Security #_____

Address: _____

Apt./Suite_____ Zip Code:_____ City:_____ State:_____

Marital Status: M D S W

Primary Care Provider_____

Pharmacy: _____ Location: _____

Contact Information:

Home Phone#: _____ Cell Phone#:_____

Would you like to receive text messages? Y or N

Work Phone #: _____ Email: _____

Other Information:

Language: _____ Hispanic /Latino Y or N Race: _____

Emergency Contact Information (That does not live with you)

Name: _____ Relationship: _____ Phone# _____

Insurance Company

Insurance Company: _____ Group #: _____

Member I.D. #: _____

IF NOT "SELF" THEN PLEASE FILL IN INSURANCE SUBSCRIBERS INFORMATION IN THE DETAILS BELOW

Subscribers First Name: _____ Middle: _____ Last: _____

Sex: _____ Date of Birth: _____ Social Sec. #: _____

Address if different than yours: _____

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices from First Choice Ankle Foot Care Center, PLLC and that I have read (or had the opportunity to read) and understood the Notice.

Patient Name (please print) _____

Parent of Authorized Representative (if applicable)_____

Signature: _____ Date: _____

The following person (s) has my permission to discuss the checked patient info.

NAME	ALL	APPTS	BILLING	TESTS	RX
_____	___	___	___	___	___
_____	___	___	___	___	___

GUARANTOR ACCOMPANYING MINOR CHILD

PARENT NAME: _____

DOB: _____ SS # _____

PHONE #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

All patients under the age of 18 are required to be accompanied by an adult listed on privacy practices sheet. If for some reason, the documented adult cannot be present a written note stating person accompanying minor patient is required or patient will be rescheduled.

FINANCIAL POLICY

Copayments: All copayments are due at the time of service. If you are unable to pay your copayment at the time of service, your appointment may be rescheduled.

Deductibles/Co-Insurance: You may be asked to pay a down payment toward your insurance deductible or co-insurance at the time of service. Any overpayments will be held on the account as a credit and applied toward future visits.

Patient Balances: Prior patient balances will be collected before you are seen. If you are unable to pay the balance in full, you will be required to set up a payment plan with our billing office.

Family Billing: Our practice tracks balances by households. You may be asked to make payment on an account for someone in your household.

Self-Pay: patients are required to pay at the time services are rendered.

Medical Records/Medical Forms: Patients are entitled to one free copy of medical records. You will be charge $1.00 per page for future copies. Completion of Disability, FMLA, Workers Comp paperwork requires a charge of $25.00 per occurrence.

Returned Checks: There is a $50.00 charge for any returned check. You will be required to pay the fee plus original balance PRIOR to scheduling a future appointment. Failure to pay the balance & fee will result in a summons from Shelby County Attorney's Office.

Bankruptcy: If a balance is written-off due to bankruptcy, any future visit(s) by any member of the household will require a $150.00 down payment on account before being seen.

Collections: Accounts over 120 days that are sent to collection will have an additional fee up to 34% collection fee added to your outstanding balance, and you could be discharged from the practice.

Insurance Information: Our office will charge a $20.00 fee to re-file claims with a correct insurance carrier that was not given to our practice at the time of service.

Controlled Substance (Green Script) Refill(s): Due to requirements mandated by the State of Kentucky, a $10.00 administrative charge will be applied to every controlled substance refill outside of an office visit. The charge must be paid before green script will be release to patient.

Medication Prior Authorization Charge: Medications that require a Prior Authorization Form by your insurance company will be subject to a $20.00 administration fee. The fee must be paid before forms are filled out. Collection of the fee does not guarantee approval of the medication through your insurance company.

Credit Card Authorization: Due to increasing billing expense and patient financial responsibility. First Choice is asking to keep your credit card information on file. The last four digits of the card are the only information that is seen from our office & is securely stored.

No Shows: Our practice requires a 24-hour notice to cancel an appointment or it is considered a "No-Show". Arrival time more than 15 minutes late may be counted as a "No Show" a $25 fee must be paid PRIOR to making a future appointment.

Worker's Compensation Claim: Claims due to work/school injury must have all information obtained prior to their visit. If information is not provided, the patient will be required to reschedule for a future date or be treated as a "Cash Pay" patient.

Auto Insurance: Our office does not accept auto insurance. Those patients will be treated as "Cash Pay".

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF FIRST CHOICE ANKLE & FOOT CARE CENTER, PLLC. IF I HAVE ANY QUESTIONS REGARDING THIS POLICY, I WILL CONTACT THE BILLING DEPARTMENT. I AGREE TO THE TERMS PUT FORTH IN THIS POLICY.

Patient Signature: _____ Date_____ Date of Birth_____

Revised 11/2016

First Choice Ankle & Foot Care Center, PLLC.
1701 Midland Trail
Shelbyville, KY 40065

PAYMENT FOR ALL PROFESSIONAL SERVICES RENDERED ARE THE RESPONSIBILITY OF THE PATIENT. NECESSARY FORMS MUST BE COMPLETED TO HELP EXPEDITE THIRD PARTY PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF THIRD PARTY COVERAGE (EXCEPTIONS STATED BELOW).

Assignment of Benefits
Authorization for Medical Care

I authorize **First Choice Ankle & Foot Care Center, PLLC**., holder of medical or other information about me, to release to the Social Security Administration and/or the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carrier or any other insurance company any information needed for this or a related Third Party claim. I permit a copy of this signed authorization to be used in place of the original document.

I assign benefits and request that payment for authorized benefits be made on my behalf to **First Choice Ankle & Foot Care Center, PLLC.,** for any services furnished to me by **First Choice Ankle & Foot Care Center, PLLC.,**. I understand that **First Choice Ankle & Foot Care Center, PLLC.** accepts assignment and agrees to accept what the insurance company allows or approves as payment in full for the claim. I assign **First Choice Ankle & Foot Care Center, PLLC.** the right to file appeals if benefits are denied. Regulations pertaining to Medicare and Medicaid assignment of benefits apply.

I understand that, by signing this document, I request **First Choice Ankle & Foot Care Center, PLLC.** to submit claim(s) for payment of services provided to me by First Choice Ankle & Foot Care Center, PLLC. providers. In addition, I authorize release of medical information necessary to pay the claim(s). If item 12 and/or 13 of the CMS-1500 Claim Form is completed, my signature authorizes release of the information to the insurer or agency shown.

In Third Party assigned cases, **First Choice Ankle & Foot Care Center, PLLC.** agrees to accept the charge determination of the Participating Third Party Company as the full charge. I am responsible only for the deductible, coinsurance, non-covered and any non-participating company services. For any denied payments, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT. The coinsurance, deductible and non-covered services are based upon the charge determination of the insurance provider.

I consent to medical and/or surgical examination and treatment, as needed, and authorize the release of information necessary to obtain payment for services rendered. I further understand and consent to my medical provider being accompanied in the exam room by a nurse or other staff person to assist in my exam or care.

_____ _____

Patient/Guardian Signature Date