Fixing Feet Institute
14823 W. Bell Rd., #100
Surprise, AZ 85374
Phone: 623-584-5556
Fax: 623-584-0755

We are pleased to Welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. This information will enable our physicians to take better care of your concerns. If you have any questions we will be glad to help you.

Patient Information

Name: _____ SS#: _____
Last Name First Name Middle Initial

Mailing Address: _____
Street Address Apt/Space Number if applicable

City:_____State: _____Zip+4: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail Address:_____

____ Male ____Female Age: _____ Date of Birth: _____

Please circle One: Single Married Widowed Divorced Separated

Employer:_____ Job Title:_____

Responsible Party Information
(Person Responsible for Payment of Account)

Name of Responsible Party: _____SS#:_____

Mailing Address: _____
Street Address Apt/Space Number if applicable

City:_____State: _____Zip+4: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail Address:_____

____ Male ____Female Age: _____ Date of Birth: _____

Relationship to Patient: _____

Whom may we thank for referring you to our office today? _____

Patient Name _____ **Date** _____

Why are you here to be treated today ? _____

_____

_____

Podiatric History

Have you ever seen a Podiatrist before? _____ If Yes,

Who_____ When _____

Athletic Activities that you participate in (please list and indicate frequency)

1._____ How Often _____
2._____ How Often _____
3._____ How Often _____
4._____ How Often _____

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

Ankle Pain	Y N	Athlete's Foot	Y N	Bunions	Y N
Corns/Callouses	Y N	Cramps/Numbness	Y N	Flat Feet	Y N
Foot or Leg Cramps	Y N	Heel Pain	Y N	Ingrown Nails	Y N
Plantar Warts	Y N	Swelling Ankle/Feet	Y N	Tired Feet	Y N

Medications
Including Prescriptions, Over-the-Counter Meds and Herbal Supplements

Medication Name Dosage/Frequency Reason for Taking

_____
_____
_____
_____
_____
_____
_____

Do You take Oral Contraceptives? YES NO

Pharmacy Name _____
Pharmacy Phone_____ Fax _____

ALLERGIES
(Circle all that apply)

Adhesive/Tape	Anticoagulant Therapy	Aspirin
Codiene	Demerol	General Anesthetics
Iodine	Local Anesthetics	Penicillin
Seafoods	Sulfa	Latex

Others (Please List)_____

_____

Patient Name _____ **Date** _____

General Medical History

Please check if you currently or have ever had any of these conditions:

[ ] Diabetes
[ ] Acid Reflux
[ ] AIDS/HIV
[ ] Anemia
[ ] Angina
[ ] Arthritis
[ ] Artificial Heart Valve(s)
[ ] Artificial Joints
[ ] Asthma
[ ] Back Pain or Problems
[ ] Bladder Infections
[ ] Bleeding Disorders
[ ] Blood Transfusions
[ ] Cancer
[ ] Chemical Dependency
[ ] Chronic Diarrhea
[ ] Circulatory Disease
[ ] Ear Problems
[ ] Emphysema/Bronchitis
[ ] Epilepsy or Convulsions
[ ] Eye Problems
[ ] Fainting or Dizziness
[ ] Fibromyalgia
[ ] Foot or Leg Cramps
[ ] Gallbladder Problems
[ ] Gout
[ ] Headaches
[ ] Heart Attack
[ ] Heart Disease or Problems
[ ] Hemophilia
[ ] Hepatitis or Jaundice
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Joint Pain or Stiffness
[ ] Kidney Problems, Stones or Dialysis
[ ] Liver Disease
[ ] Low Blood Pressure
[ ] Lung Problems
[ ] Mitral Valve Prolapse/ Heart Murmur
[ ] Nerve Disorder
[ ] Neuropathy
[ ] Open Sores
[ ] Phlebitis or Blood Clots
[ ] Pneumonia
[ ] Polio
[ ] Psychiatric Care
[ ] Radiation Treatment
[ ] Rheumatic Fever
[ ] Scarring Tendencies
[ ] Shortness of Breath
[ ] Sickle Cell Disease
[ ] Sinus Problems
[ ] Skin Problems
[ ] Sleep Apnea
[ ] Stomach Ulcers
[ ] Stroke
[ ] Swelling in Legs or Feet
[ ] Thyroid Disorder
[ ] Tired Feet
[ ] Tuberculosis
[ ] Varicose Veins
[ ] Weight Loss, unexplained

Other _____

Comments_____
_____
_____

Please list all Surgeries you have had and the approximate date they occurred.
_____
_____
_____

Please List All Hospitalizations (Not Related to above surgeries) and the approximate date they occurred.
_____
_____
_____

Who is your Family Physician? _____Date of Last Visit_____

Family Physician Phone Number _____

Who should we notify in the case of an Emergency :

Name _____Phone #1 _____

Relationship to Patient _____Phone #2_____

Patient Name _____ Date _____

Social History

Marital Status [ ] Single [ ] Married [ ] Divorced [ ] Widow/Widower

Tobacco Use: [ ] Never [ ] Former [ ] Sometimes [ ] Everyday

Alcohol Use: [ ] Never [ ] Former [ ] Sometimes [ ] Everyday

Race: [ ] Not Specified [ ] American Indian/Alaskan Native [ ] Asian [ ]Black/African American
[ ] Native Hawaiian/Pacific Islander [ ] White/Caucasian

Ethnicity: [ ] Hispanic/Latino [ ]Not Hispanic/Latino

Patient Permission

I give Fixing Feet Institute permission to leave a voice mail message at this number _____
Home / Cell / Work

I give permission for message's to be left concerning:
Check all that apply

_____ Appointment Issues

_____ Billing Issues

_____ Medical/Treatment Issues

The same information may also be given to the following persons:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Patient/Guardian Signature _____Date_____

MEDICAL STAFF USE ONLY:

Weight _____ Height _____ Blood Pressure _____

Pulse _____ BMI _____ Shoe Size _____

Patient Name _____ Date _____

Please <u>INITIAL</u> next to each section:

_____I hereby give my permission to Dr Peyman Elison and/or Dr. Viedra Elison to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and /or treatment of my foot condition(s).

_____I hereby authorize Dr. Peyman Elison and/or Dr. Viedra Elison and their staff to prescribe and refill medication through a computerized e-prescribing system. I understand that my physician may be sending my prescriptions electronically, and I have been informed on the e-prescribing process. I also give permission for Fixing Feet Institute to obtain my medication history from my pharmacy, my health plans, and other healthcare providers.

_____I hereby authorize Dr. Peyman Elison and/or Dr. Viedra Elison and staff to release any information acquired in the course of my examination for insurance purposes.

_____I hereby authorize any physician, hospital or medical care facility to provide all information on my medical history and treatment to Fixing Feet Institute.

_____I hereby authorize payment directly to the business office of Fixing Feet, PLLC on behalf of Dr. Peyman Elison and/or Dr. Viedra Elison for the surgical and /or medical benefits, if any, otherwise payable to me for the services. I understand that I am financially responsible for the charges not covered by insurance..

_____I will notify Fixing Feet Institute immediately with any insurance, address or contact information changes. Otherwise, I will be held responsible for all actions incurred by inaccurate/outdated information.

_____If eligibility of insurance cannot be verified, or if deductible, out of pocket or co-insurance has not been met, I understand that I will be responsible for the cost of all medical services rendered.

I hereby authorize photocopies of this authorization and my signature to be valid as the original

_____ _____

Patient/Guardian Signature DATE

NOTICE OF PRIVACY PRACTICES

The law requires us to keep your medical information private. The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services that you receive in our office. We need this record to provide you with quality care and to comply with certain legal requirements. We may use this information to provide you with medical treatment or services. We may also disclose medical information about you to doctors, nurses, technicians, insurances and other people who are taking care of you.

I acknowledge that I was provided a copy of the Notice of Privacy Practices for Fixing Feet Institute, PLLC, and that I have read (or had the opportunity to read if I so chose) and understood the notice.

_____ _____

Patient/Guardian Signature DATE

Patient Name _____ **Date** _____

FINANCIAL AGREEMENT

Thank you for choosing Fixing Feet, PLLC. We welcome you and are committed to providing quality care.

Please carefully read the following statement of our financial policy prior to treatment. You will be given an opportunity to speak with one of our staff if you have any questions.

It is your responsibility to be aware of your insurance benefits. Exclusions, pre-existing conditions, and terminated health benefits may nullify insurance coverage and transfer financial obligation to the responsible party. Plan specifics, such as deductibles, co-insurance, or non-covered charges, are the responsibility of the patient to be aware of. If you are unclear of your benefits, you will need to contact your insurance carrier for clarification of your coverage.

If you have an insurance carrier which requires referrals or authorizations for care, it is your responsibility, as the patient to obtain any necessary referrals or authorizations to be treated. Please keep track of expiration dates and number of visits allowed, as you will be responsible for obtaining new referrals/authorizations upon their expiration. Many primary Care Physicians are now requiring up to 14 day notice to issues a referral or authorization.

If you are a self-paying patient or wish to submit your own insurance claim, we will require payment in full at the time of service, unless other arrangements are made in advance. For larger balances, we can assist you in obtaining Care Credit assistance.

Payment is due prior to the time of service. You are responsible for any unpaid balance on your account. Our office accepts cash, personal checks, and debit/credit cards with the VISA, MasterCard, Discover, or American Express Logo. We also participate with Care Credit services.

In the event that, after your insurance company payments have been made, and your account is left with a balance, that balance will be due from you within thirty (30) days. Statements will be sent out on a monthly basis. If your account is not paid in full within sixty (60) days, interest may accrue at a monthly rate of 1.5%. There will also be a $25 charge for any returned checks.

My Signature below confirms that I have read the above statement regarding the financial policy and agree to abide by the contents thereof.

_____ _____

Patient/Guardian Signature DATE

NO SHOW POLICY

In order to provide the best possible service and availability to our patients, it is our policy to charge $25.00 for any appointments that are not kept and were not cancelled with at least 24 hour notice. Please call us as early as possible if you need to cancel or reschedule your appointment so we can offer that time to another patient. As a courtesy reminder calls are placed 1-2 business days prior to your appointment, but it is still the patient's responsibility to remember their appointment.

I have been notified of the office No Show Policy and I agree to be <u>personally</u> responsible for payment of the No-Show Fee under the terms outlined above. No Show Fees cannot and will not be billed to Medicare or your insurance carrier.

_____ _____

Patient/Guardian Signature DATE

PATIENT PRIOR AUTHORIZATION POLICY

It is the responsibility of our insured patients to be aware of any restrictions or requirements stated in their insurance policy. These include deductibles, second opinions, policy exclusions or waived benefits, precertification requirements, and any other restrictions.

As a COURTESY, our office will contact your insurance company for verification of your benefits or pre-authorization requirements. However, a pre-authorization issued by your insurance company simply means that they agree that your office visit, medication, surgery, orthotics or other DME (durable medical equipment) item is medically necessary, however this does not guarantee payment by your insurance company. A standard disclaimer given by all insurance companies that any information given is an estimate of coverage and final determination cannot be made until the claim is received. What this means is:

Verification of Benefits or Prior Authorization does NOT guarantee payment from your insurance company. The patient is ultimately responsible for payment.

Your insurance benefits and the payment we receive are determined by the limits set by your insurance carrier.

It is your responsibility to be aware of your benefits and limits.

A deposit may be required, if you have not met your deductible or out of pocket expenses limit, at the time of service.

By signing below, I understand that I am responsible for the charges not covered and paid by my insurance.

_____	_____	_____
Patient/Guardian Name (Printed)	Patient/Guardian Signature	DATE