Welcome to Bluegrass Regional Foot & Ankle

Name: _____ **Preferred Name:** _____
First *Middle* *Last*

SS#: _____-_____-_____ **DOB:** _____/_____/_____ **Sex:** ☐ M ☐ F

Email: _____

Address: _____
Street *City* *State* *Zip*

Home #: (_____) _____ - _____ **Work #:** (_____) _____ - _____ **Cell #:** (_____) _____ - _____

Marital Status: ☐ Divorced ☐ Legally Separated ☐ Married ☐ Partner ☐ Single ☐ Widowed

Employment Status: □ Full-time □ Part-time □ Not Employed ☐ Retired **Occupation:** _____

How did you hear about our office? ☐ Internet ☐ Facebook ☐ Newspaper ☐ Phonebook ☐ Saw Sign

☐ Other ☐ Healthcare Provider: _____ ☐ Patient: _____

Primary Care Provider: _____ **Approximate Date Last Seen:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone** (___) _____ - _____

CURRENT MEDICATIONS

Please list current medications, including topical creams, vitamins/supplements, & all over-the-counter medications:

Preferred Pharmacy: _____

☐ **No Medications**

****EXAMPLE:** Metformin_____ Dose _500mg__ Freq: 2X Day_

Name: _____ **Dose** _____ **Freq:** _____

Name: _____ **Dose** _____ **Freq:** _____

Name: _____ **Dose** _____ **Freq:** _____

Name: _____ **Dose** _____ **Freq:** _____

Name: _____ **Dose** _____ **Freq:** _____

Name: _____ **Dose** _____ **Freq:** _____

Name: _____ **Dose** _____ **Freq:** _____

Name: _____ **Dose** _____ **Freq:** _____

Name: _____ **Dose** _____ **Freq:** _____

Name: _____ **Dose** _____ **Freq:** _____

Name: _____ **Dose** _____ **Freq:** _____

Use the back of this form if more room is needed

ALLERGIES

Please select any known allergies:

☐ **No Known Allergies**

☐ **Penicillin**

☐ **Sulfa**

☐ **Adhesive Tape**

☐ **LATEX**

☐ **Betadine (iodine)**

☐ **Aspirin**

☐ **Tylenol/Acetaminophen**

☐ **Ibuprofen**

☐ **Erythromycin**

☐ **Codeine**

☐ **Other (*Please specify*):**

_____

_____

_____

_____

_____

_____

_____

HISTORY OF PRESENT CONDITION

What is the reason for your visit today? _____

How long have you had this issue? _____

What treatments have you tried & have they been effective? _____

_____

REVIEW OF SYSTEMS (ROS):

NOTE: FOR THE NEXT 5 BOXES BELOW, PLEASE MARK ANY SYMPTOMS/CONDITIONS YOU ARE CURRENTLY AND/OR RECENTLY EXPERIENCING. IF NONE APPLY, PLEASE BE SURE TO NOTE "DENIES ALL".

MUSCULOSKELETAL– IF NONE APPLY, PLEASE MARK "DENIES ALL" BOX

☐ Foot or Ankle Pain ☐ Back or Hip Pain ☐ Muscle Cramps in Foot or Legs ☐ Recent Falls or Balance Problems

☐ OTHER: _____ ☐ **DENIES ALL**

SKIN/INTEGUMENTARY – IF NONE APPLY, PLEASE MARK "DENIES ALL" BOX

☐ Dry or Itchy Skin ☐ Skin Rash ☐ Skin Infection ☐ Skin Ulcers ☐ Painful or Infected Ingrown Toenails

☐ Corns/Callouses ☐ Wart(s)

☐ OTHER: _____ ☐ **DENIES ALL**

NEUROLOGICAL – IF NONE APPLY, PLEASE MARK "DENIES ALL" BOX

☐ Burning, Tingling or Numbness in Feet or Legs ☐ Sharp Shooting Pain in Feet or Legs

☐ OTHER: _____ ☐ **DENIES ALL**

CARDIOVASCULAR – IF NONE APPLY, PLEASE MARK "DENIES ALL" BOX

☐ Swelling in Feet or Legs ☐ Varicose Veins ☐ Cold Feet

☐ OTHER: _____ ☐ **DENIES ALL**

CONSTITUTIONAL – IF NONE APPLY, PLEASE MARK "DENIES ALL" BOX

☐ Fever ☐ Pregnancy ☐ Shortness of Breath

☐ OTHER: _____ ☐ **DENIES ALL**

PATIENT HISTORY:

NOTE: FOR THE NEXT 3 BOXES BELOW, PLEASE MARK ALL BOXES THAT APPLY TO YOU (CURRENTLY OR IN THE PAST).

MEDICAL HISTORY – IF NONE APPLY, PLEASE MARK "DENIES ALL" BOX

☐ Alzheimers or Dementia ☐ Anxiety ☐ Depression ☐ Diabetes ☐ GERD ☐ Gout ☐ Heart Disease ☐ Hepatitis

☐ High Blood Pressure ☐ Kidney Disease ☐Liver Disease ☐ Lung Disease ☐ Multiple Sclerosis ☐ Neuropathy

☐ Pacemaker ☐ Seizures ☐ Stroke ☐ Thyroid Disorder

☐ OTHER: _____ ☐ **DENIES ALL**

SURGICAL HISTORY – IF NONE APPLY, PLEASE MARK "DENIES ALL" BOX

☐ Ankle surgery ☐ Foot surgery ☐ Heart surgery or STENTS ☐ Hip Replacement ☐ Kidney surgery ☐ Knee Replacement ☐ Low Back surgery ☐ Neck surgery ☐ Shoulder surgery ☐ Vascular surgery ☐ Weight loss surgery

☐ OTHER: _____ ☐ **DENIES ALL**

SOCIAL HISTORY – IF NONE APPLY, PLEASE MARK "DENIES ALL" BOX

☐ Smoker ____# packs per day ☐ Former Smoker ☐ Alcohol Use ____ # drinks per week ☐ **Other** Tobacco Use

☐ Illicit Drug Use ☐ History of Alcohol Abuse ☐ History of Drug Addiction ☐ **DENIES ALL**

BRFAA Policies & Procedures

MEDICAL RECORDS - We are committed to protecting the security and privacy of your personal information. Medical records are the property of **BRFAA**, kept in a secure location, and are accessed for purposes outlined by the Notice of Privacy Practices. Records may be shared with other healthcare providers for your treatment. Patients are entitled to **one free copy** of their medical records with signed release.

List any other person(s) that we may release your medical information to:

_____

COMMUNICATION POLICY – **BRFAA** has permission to call and/or text your home, cell, and place of employment for healthcare reasons, appointment reminders, or to resolve billing issues **IF THOSE NUMBERS AND FORMS OF COMMUNICATION ARE PROVIDED**. In addition, we may mail informational postcards to your home as well as billing statements and medical information. **BRFAA** may leave messages on your answering machine regarding appointments and *limited* lab information. We may also use your email address to send updates about our office, billing statements, and appointment reminders. If you would like to opt-out of any of the above methods of communication, please advise us.

PROVIDER POLICY - In the course of your treatment with BRFAA, you may see either: Daniel Albertson, APRN, Dr. Paul Krestik, Dr. Heather Jones, Dr. Ariel Sexton or Dr. Shana Shetty. If you have a preference of provider, please notify a team member and we will make every effort to accommodate your preference. Once you are established, you will continue to see that provider for the duration of your care.

MISSED APPOINTMENTS/NO SHOW FEE - Failure to cancel your appointment without reasonable notification may result in a **penalty fee of $25**. **NOTE: This is a no show/no call fee; fee can be avoided by communicating inability to keep appt.** This fee is NOT covered by insurance.

RETURN CHECK POLICY – ALL returned checks are immediately sent to the county attorney's office who will charge a **$50 fee** on our behalf plus the cost of the check in addition to a **$50 fee** for the county attorney's office. They will give you 10 days to pay in full or a bench warrant will be issued for your arrest.

CUSTOM PRODUCT POLICY - Some of our treatment plans involve ordering/dispensing custom products. It is our policy at BRFAA that with your permission, we will order (and **pre-pay** for**)** custom products on your behalf. Custom-made products are specific to you and typically cannot be returned to the vendor for credit nor can it be dispensed to anyone other than you. Also, typically, the item cannot be billed to your insurance until it is dispensed to you. If you agree to have a custom product ordered, you also must agree to return to the office for dispensal of the product so that we can bill the insurance and get reimbursed for the item. Failure to return to the office to pick up custom products could result in you being fully financially responsible for the custom item.

REFERRALS – The insurance policy holder is responsible for **ALL** insurance authorizations or managed care referrals, as necessary, for payment of services rendered. If you fail to obtain a referral or fail to have an active referral on file, you may be financially responsible for those charges if the insurance denies. BRFAA is **NOT** responsible for obtaining these entities.

HMO POLICY – THIS POLICY ONLY APPLIES TO THOSE THAT HAVE A HMO POLICY WITH THEIR INSURNACE: If you have a HMO policy and require a referral to be seen, we will not be able to see you and bill your claim as we do not maintain nor file with any insurance policy that requires a written referral in order to be seen. You will need to schedule at a practice that will obtain the referral. We apologize for any inconvenience this may cause.

Patient Insurance Information

Primary Insurance: _____ **Are you the policy holder? ☐Y ☐N**

Policy Holder Information

Name: _____ Relationship to patient: ☐ Spouse ☐ Parent ☐ Self ☐ Other

Sex: ☐ M ☐ F DOB: _____/_____/_____

Member ID: _____ Group #: _____ Employer: _____

Secondary Insurance: _____ Are you the policy holder? ☐Y ☐N **NOT APPLICABLE** ☐

Policy Holder Information

Name: _____ Relationship to patient: ☐ Spouse ☐ Parent ☐ Self ☐ Other

Sex: ☐ M ☐ F DOB: _____/_____/_____

Member ID: _____ Group #: _____ Employer: _____

FINANCIAL OBLIGATION

(To be completed by BRFAA employee & explained to you, the patient)

☐ Medicare ONLY $_____ deductible, $_____ remains, 20% co-ins. after deductible is met.

☐ **HMO POLICY** – I have read the "HMO Policy" above and fully understand if I choose to still be seen today, BRFAA will not obtain a written referral nor will they file my claim to my insurance my responsibility

☐ Co-pay of $ _____ per visit.

☐ Co-insurance of _____%.

☐ Multiple insurance carriers:

We will submit to both insurances and you will be responsible for any outstanding balance after both insurance carriers process your claim.

☐ Claim Submission

We will submit claim to your insurance. You will be responsible for any balance after they pay.

☐ Deductible has not been met – **I understand that I am fully responsible for today's allowable charges at the fee schedule rate and this amt. will be collected today.**

$_____ deductible, $_____ remains; responsible for _____% co-insurance once met.

☐ Self-pay/No insurance **– I agree to pay IN FULL for all services rendered on date of service.**

☐ Refuge Clinic Patient. Date last applied for KY Medicaid: _____

Comments:_____

BRFAA Payment Agreement

PAYMENT IS DUE AT THE TIME OF SERVICE – <u>ALL Co-pays, deductibles, co-insurances/percentages, non-covered charges, and self-pay services are COLLECTED ON THE DATE SERVICES ARE PROVIDED.</u> If you are unable to pay today, please let the receptionist know and we will be happy to reschedule your appointment for a future date. We have verified your insurance benefits prior to being seen, but please note this is only an **ESTIMATE** and not a guarantee. We are not responsible for any misinformation from the insurance company. Your insurance is a contract between you and the insurance company. Our office **CANNOT** guarantee that your insurance carrier will pay your claim. If your claim is denied by your carrier, the obligation for payment is the responsibility of the patient. If you wish to contest any denied service or procedure, it is your responsibility to discuss that with your insurance. We will, however, be happy to assist wherever possible. Any changes to your **demographics** or **insurance** must be brought to our attention **BEFORE** being seen. Failure to do so may result in the patient being responsible in **FULL** for all charges of services rendered.

OUTSTANDING CHARGES – Balances owed over 30 days may be charged a **$20 late fee** for every 30 days that the payment remains overdue. If your bill remains overdue greater than 90 days, it may be turned over to an outside collection agency at which point a **$20 collection fee** will be added and then the bill will be out of our hands. All outstanding bills must be settled **PRIOR** to receiving care, unless arrangements have been made with our office. We will make every attempt to help you.

By signing the bottom of this page, you give us permission to bill your insurance and to release to them all information necessary to secure payment. In addition, you are agreeing to be responsible for all charges not covered by your insurance or charges your insurance deems your responsibility including any self-pay services.

Also, by signing, you certify that the medical information that you have included on the previous forms is true and correct to the best of your knowledge. In addition, you are giving permission to Bluegrass Regional Foot and Ankle Associates to administer and perform such procedures as may be deemed necessary for diagnosis and/or treatment.

*Lastly, by signing, you attest that you have carefully read and agree to our Policies and Procedures that are listed above. These policies have been established to help us continue to provide you with the best quality of medical care. If you have any questions or concerns about these policies; please ask for the **Practice Manager**.*

<u>Covid-19 Questionnaire</u>

Please circle any that apply.

Fever/Chills: Yes or No

Recent Exposure: Yes or No

Loss of taste/smell: Yes or No

Print Name: _____ **Date: _____**

PATIENT (or Guardian) **Signature: _____**