Premier Foot & Ankle

821 S. Horner Blvd , Sanford, NC 27330
Phone (919- 292-1610 Fax (919) 292-1613
Dr. Ronald M. Talis DPM, FACFAS Dr. Elene Papakostas, DPM Dr. Jacqueline Aranas, DPM, AACFAS

First: _____ **Last**: _____**(MI)** _____ **Birthdate**: _____/_____/_____

SSN: _____ **Gender**: Male or Female **Age**: _____

Address: _____

City: _____ **State**:_____ **Zip**:_____

Home Phone:_____ **Cell**: _____ **Work**:_____

Email: _____ **Emergency Contact & Phone**: _____

Employer: _____ **Occupation:** _____

Pharmacy:_____ **Number:** _____

Primary care doctor: _____ **Last Seen:** _____

⇒ **Chief foot/ ankle/ leg complaint today**? _____

⇒ **How long has it been bothering you**? _____

- Date of injury if applicable? _____

⇒ **Previous treatments**? _____

MEDICAL HISTORY (Check all that apply)

__ AIDS/HIV	__ Acid Reflux (GERD)	__ Epilepsy	__ COPD	__ High Blood Pressure
__ Anemia	__ Cataracts	__ Gout	__ Stroke	__ Atrial fibrillation
__ Arthritis	__ Cholesterol	__ Joint Pain	__ Stomach Ulcers	__ Heart Disease
__ Asthma	__ Chest Pain	__ Hepatitis	__ Tuberculosis	__ Heart Valve Replacement
__ Anxiety	__ Chronic Headaches	__ Varicose veins	__ Thyroid	__ Joint Replacement
__ Depression	__ Fibromyalgia	__ Liver Disease	__ Cancer/Type? _____	

- Are you currently pregnant or breastfeeding? _____
- **Kidney Disease**: YES or NO If yes, are you on Dialysis? YES or NO
- Are you **DIABETIC**? YES or NO

  *IF YES, what was your **last HbA1c**?* _____**Date of HbA1c:**_____ *Morning Fasting Blood Sugar*? _____

  CIRCLE TYPE OF TREATMENT(S): *Insulin* *OR* *Pills*

- Have you had any previous ulcers? [LIST WHEN AND WHERE] _____

OTHER medical condition(s) NOT listed: _____

Family History	Social history			
☐ Limb Loss	**Marital Status**	**Alcohol**	**Recreational Drugs**	**Nicotine**
☐ Diabetes	☐ Single	☐ Never	☐ No	☐ Never
☐ Heart Disease	☐ Married	☐ Rare	☐ Yes	☐ Former, quit in _____
☐ Cancer	☐ Divorced	☐ Occasional	List: _____	☐ Current, Packs per day?
☐ Keloid Scars	☐ Widowed	☐ Frequent	_____	_____
☐ Sickle Cell Disease	☐ Live Alone			
☐ High Blood Pressure				

List Medications: _____

_____

Allergies: _____

List ALL surgical procedures: _____

Have you fallen in the last 12 months? YES or NO **If yes, how many?** _____

Do you feel steady? YES or NO **Do you use a cane or walker?** _____

Last Flu Shot received: _____

Are you under regular care of any other doctors? _____

Whom may we thank for referring you? _____

Important: May we leave medical information on your home answering machine, voice mail or with a family member for appointment reminders, lab results, insurance coverage, etc?

No_____ Yes_____ If no, please list the number we should use: _____

Consent: I certify that the information in this packet is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/ or treatment of my feet, ankles and lower legs. I acknowledge receipt of a copy of the Notice of Privacy Practices and agree to its terms. I hereby authorize medical information to be sent to my primary physician as well as for the purpose of processing my insurance claim.

Signature: _____ **Date**: _____

If signing for a minor, please list your relationship to the patient: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered and/or provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I chose) and understood the Notice. A hard copy is located on the front desk

Patient Name (print):_____

Parent or Authorized Representative (if applicable)

_____

Signature: _____

Office use: Vitals: Height ____ Weight: ____ BP: _____ Pulse:_____ RR:_____ Shoe size:_____

Patient Financial Policy for Premier Foot & Ankle

Your understanding of our financial policy is an essential element of your care and treatment. If you have any questions, please discuss them with the front office staff or supervisor.

● As our patient, we will attempt to verify benefits for you including some specialized services or referrals. However, you are responsible for all authorizations/referrals needed to seek treatment with us. Patients are encouraged to contact their insurance plan for clarification of benefits prior to services rendered.

● Your insurance policy is a contract between you and said company. We will file your insurance claim for you. You agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

● We have made prior arrangements with certain 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 copay/coinsurance/deductible at the time of service. If you have insurance coverage with a plan with which we do not have a prior agreement, all charges for your care and treatment are due at the time of service.

● All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge.

● You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied or recouped.

● We will bill your insurance for services performed in the hospital. Any balance is your responsibility.

● All elective surgical procedures require pre-payment of a minimum of 50% of the patient's responsibility which is dictated by the insurance. This will be due one week prior to surgery. If a patient cancels surgery and does not reschedule within 30 days, a $100 deposit will be required to reschedule. This will only be refunded (or applied towards patient responsibility) after surgery is performed. If surgery is canceled again, the $100 deposit will not be refunded, unless cancellation was secondary to extraordinary circumstances.

● Past due accounts are subject to collection proceedings. All costs incurred (ex: collection fees, attorney fees and court fees) shall be your responsibility in addition to the balance due this office.

● A $25 fee will be added to your account for any cancellation not received within 24 hours of your appointments except for extraordinary circumstances which can be discussed with the office manager.

● There is a service fee of $25 for all returned checks. Your insurance company does not cover this fee.

We understand certain procedures and equipment may be required by a patient at some point during treatment. We try to be mindful of cost as well as rules and regulations given to us (the Providers) by the insurance companies. Certain insurances WILL NOT COVER certain products or procedures. If you have any questions, you may discuss with the office staff but please be aware, we only FOLLOW the patient's insurance policy.

PATIENT'S MUST INITIAL AT EACH AREA BELOW STATING UNDERSTANDING OF EACH

A. DURABLE MEDICAL EQUIPMENT (DME): Payment for DME and other over the counter products are due at the time of service. The insurance company will be billed for DME at the patient's request. We can try to give an approximate estimate regarding cost of DME products, however, the insurance company the patient has partnered with will ultimately assign the patient's financial responsibility for this product. Patients have the right to ask the office not to bill the insurance company and may ask for a self pay rate. None of the over the counter products are covered by insurance.

I understand the above statement labeled "A": INITIAL HERE_____

Patient Financial Policy for Premier Foot & Ankle

B. DME Specifically concerning Medicare: One DME product is covered by Medicare **ONE TIME PER FIVE YEARS** regardless of where the product was dispensed and by which provider. If you are aware of a certain product having been dispensed in the past 5 years, please make the office aware. If any charges occur because the office was not informed, the patient is responsible for payment.

I understand the above statement labeled "B": INITIAL HERE_____

I do not have Medicare and this is not applicable to me: INITIAL HERE _____

C. INGROWN TOENAILS: As of March 5, 2023, **Medicare** will only allow payment for an **ingrown toenail** per border of each toe **once per 8 months**. Medicare will only allow payment of **a permanent ingrown nail avulsion once** in a lifetime per border per toe. If these procedures were performed under Medicare coverage in these specific time frames by any provider in any state, patients will be liable for payment at the self pay rate. **It is the patient's responsibility to inform the office.** If a patient fails to inform the office of this procedure being performed at another location/another provider and the insurance denies for this reason, a statement of self pay rate will be mailed to the patient. Commercial insurances may change their guidelines at any time to follow Medicare guidelines.

I understand the above statement labeled "C": INITIAL HERE _____

D. NAIL CARE/ CALLUS CARE: Insurance carriers cover nail and callus care (routine foot care) every 62 days **IF** a patient has qualifying measures. Please see office staff if you wish to be provided with a copy of these guidelines. Please ask the provider **not a staff member** if you have questions as to why you do or do not qualify per these guidelines. As of now, all insurances follow Medicare guidelines for routine foot care. Patients must still pay copay, deductible, co-insurance, etc. as dictated by their insurance policy. If a patient does not have qualifying factors, nail and callus care may be performed at our self pay rate, AND the patient agrees to pay at time of service. Patients may schedule "self pay nail/ callus care" appointments at any time interval or frequency.

I understand the above statement labeled "D": INITIAL HERE _____

E. ROUTINE FOOT CARE CONT. Per Medicare guidelines, the physician's name and date last seen by the physician must be given to the office at the time of their appointment to bill for these services, and the patient must be seen by their primary care provider (or provider treating diabetes, if this is applicable to the patient), within the last 6 months.

I understand the above statement labeled "E": INITIAL HERE _____

F. SELF PAY RATE:

If a patient does not have insurance, the patient is responsible for the self pay rate which must be paid at the time of service. A patient is considered a new patient if they have not been seen for 3 years by Premier Foot and Ankle.

Patients have the right to decline for the provider to send their claim to their insurance company and can instead choose a self pay rate. Patient understands if a self pay rate is chosen, the claim will not be sent to the insurance company and the patient is responsible for this payment at the time of service. Self pay payments are not applied toward insurance deductibles.

I understand the above statement labeled "F": INITIAL HERE _____

Name of Patient/ Responsible Party:

_____

Signature: _____Date: _____

Witness Name and Signature: _____Date: _____

PREMIER FOOT & ANKLE
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Sanford, NC 27330

Please mark one of the following:

- ☐ I, _____ **allow** the following people to obtain my medical information/ records from Premier Foot & Ankle. I understand that it is my responsibility to update the office with any changes to whom I allow my medical information to be released.
- ☐ I, _____ **do not** wish any person other than myself to obtain my medical information. I understand that it is my responsibility to update the office in person in writing any changes to whom I may allow my medical information to be released.

Please check all that apply

1. Name Phone Number Relationship

_____

Medical information __Records __In Person __Over the phone

2. Name Phone Number Relationship

_____

Medical information __Records __In Person __Over the phone

3. Name Phone Number Relationship

_____

Medical information __Records __In Person __Over the phone

Signature of Patient: _____
Date: _____