PATIENT REGISTRATION FORM

Four Peaks Foot and Ankle

333 W. Thomas Rd Ste 203
Phoenix, AZ 85013
Phone Number: (480) 931-3887 FAX: (480) 931-3902

TODAYS DATE: _____/_____/_____

PATIENT NAME: _____
Last First MI

DATE OF BIRTH: _____/_____/_____ AGE: _____ SEX: M F

HOME ADDRESS: _____CITY/STATE: _____ZIP: _____

HOME PHONE #: (_____) _____-_____ SOCIAL SECURITY # _____

CELL PHONE #: (_____) _____-_____ EMAIL ADDRESS_____

NAME OF EMPLOYER: _____

JOB TITLE: _____PHONE#:(_____) _____-_____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES / NO

IF YES, NAME: _____RELATIONSHIP: _____PHONE #:(_____) _____-_____

EMERGENCY CONTACT: _____RELATIONSHIP: _____

EMERGENCY CONTACT PHONE #:(_____) _____-_____

PRIMARY CARE PROVIDER:_____PHONE # (_____) _____-_____LAST SEEN_____

HOW DID YOU HEAR ABOUT US? (Google search, Friend, Doctor etc?) _____

PHARMACY:_____LOCATION:_____PHONE # (_____)_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION? YES / NO IF YES, FAMILY MEMBER NAME & NUMBER _____

WHO IS RESPONSIBLE FOR PAYMENT? (SELF?) _____RELATIONSHIP TO PATIENT? _____

**ADDRESS IF DIFFERENT THAN ABOVE*

ADDRESS: _____CITY/STATE: _____ZIP: _____PHONE #:(____) _____-_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME:_____

ADDRESS:_____CITY/STATE:_____ZIP:_____PHONE #:(____) _____-_____

INSURED NAME:_____DATE OF BIRTH_____EMPLOYER_____

CONTRACT #_____GROUP #_____

SECONDARY INSURANCE COMPANY NAME:_____

ADDRESS:_____CITY/STATE:_____ZIP:_____PHONE #:(___) ____-_____

INSURED NAME:_____DATE OF BIRTH_____EMPLOYER_____

CONTRACT #_____GROUP #_____

PATIENT SIGNATURE: _____ **TODAYS' DATE:**_____

Hello and Welcome!

Welcome to Four Peaks Foot and Ankle and thank you for scheduling with us! We are happy that you have chosen us to help assist you in your healthcare needs. This letter provides you with valuable information regarding our office policies and procedures. Please review this letter carefully and if you have any questions or concerns, please let us know. Our goal is to make your appointment with us as enjoyable and productive as possible.

Appointment Time, Cancellations , and No Shows:

Because we put a great deal of time and effort into properly scheduling our patients, we ask that you arrive 20 minutes prior to your first appointment to fill out paperwork if not done ahead of time or there is a need to update your insurance or medical information. Otherwise, we ask that you arrive prior to your appointment so that we can run on time and respect the times of patients that are scheduled after you. Should you arrive 15 minutes after your scheduled time, we may ask that you to reappoint. We require a 24 hour cancellation notice. You will be given reminders of your appointment. If you cannot keep it, please be sure to cancel it and contact our office to reschedule. If you do not, there will be a $60.00 non-kept appointment charge. Anything less than 24 hours represents a lost opportunity to better serve a patient who may be in need of our care.

Preparation for Your Visit:

If you are filling out your patient registration information ahead of time, please be sure to fill out the paperwork in its entirety. Filling out the forms ahead of your appointment will save you time in the office and help to see you in a more timely manner. It will also ensure that we have all the necessary information to fully address your health concerns.

Photo ID
Insurance Card(s)
Primary Care Referral (if required by your insurance)
Copayment (if required by your insurance) – This is for a SPECIALIST
List of Medications

Minors:

Minors must be accompanied by a parent or legal guardian in order to be treated. If the parent or legal guardian cannot be present, the minor must have authorization to be treated. This can simply be done with a permission slip signed by the parent or legal guardian offering permission to treat the said patient. We will accept telephone permission when witnessed by 2 different staff members.

What to Expect Upon Arrival:

Upon arrival you will be greeted by one of our staff members and your registration information confirmed. If your insurance plan requires a copayment, we will ask for that amount at CHECKIN. Remember, this will be co-payment for a SPECIALIST. For your convenience, we accept cash, personal check, credit or debit cards as payment. For any patient that is SELF PAY, you will be asked to pay $75.00 for the office visit and 100% of the total services rendered. If you have insurance with a large deductible and it has not been met, you will be required to pay your copayment for the office visit and 50% of all services rendered. You will be billed for the remaining balance. Should you not have a copayment with your insurance, you will be required to pay at least $75.00 for the office visit.

What to Expect After the Visit:

Our office will submit on your behalf the claim to your insurance company. In order to bill your insurance carrier, you must supply our office with all of your current / correct information. Your insurance policy is an agreement between you and your insurance carrier. We ask that all patients seek out information needed from their insurance company, including any needed referrals. You are ultimately responsible to see that the account is paid in full. If there are any remaining balances after the insurance company(ies) have paid, we will send you the bill. Please refer to the financial policy below. Should you have any questions or concerns, please contact our billing department so that we can assist you.

Financial Policy:

We are participating providers with Medicare and do accept Medicare assignments. There is a yearly deductible that patients must meet before Medicare begins paying. You will also have a 20% coinsurance if you do not have secondary coverage. Therefore, at the beginning of the year, you may be asked to pay a portion of the office visit and services rendered. If you do have a secondary insurance, we will submit charges after Medicare. For any remaining balance, the patient by law is responsible for payment.

All Medicaid and Medicaid Managed Care patients must show a valid insurance card at each appointment before seeing the doctor. If ineligible or you are not able to provide the office with a valid insurance card, we will ask that you kindly reschedule your appointment. We are required to verify current insurance coverage.

You are responsible for timely payment on your account. We reserve the right to reschedule or deny future appointments on any delinquent accounts. Once we have received payment or denial of payment from your insurance company, you will be sent an invoice for payment. That invoice is expected to be paid in full within 30 days unless payment arrangements have otherwise been made with the office. Delinquent accounts that are neglected will be placed with an outside collection agency. With minors, it can be unclear as to who is responsible for the bill. In our office, the parent that is responsible for all fees incurred, is the parent who brings in the child in and requests treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office.

For all returned checks to us by our bank for insufficient funds there will be a service charge assessed to the patient's account of $30.00.

It is our hope that the above Financial Policy will allow us to provide care to our valued patients. If you need clarification on any of the above policies, please do not hesitate to contact our office.

Four Peaks Foot and Ankle

_____ _____

Signature of Patient or Legal Guardian Today's Date

Notice of Privacy Practices and HIPAA

As a patient of Four Peaks Foot and Ankle we want to provide you with the best possible care. We want you to feel free to make full disclosure of information to the physician so that effective treatment can be provided. As required by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Four Peaks Foot and Ankle, is providing you, the patient of the patient's legal representative, with a copy of our Privacy Notice. HIPAA regulations require us to provide this information to you and to obtain your signature or the signature of your legal representative as proof that you have received our Privacy Notice. *Our policy is to protect the confidentiality, integrity, and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use of such information. This policy applies to both current and former patients.*

Protected Health Information (PHI) is individually identifiable health and personal information and includes any information obtained by Four Peaks Foot and Ankle, in connection with providing health care treatment, obtaining payment and related healthcare operations. This relates to past, present for future information that Four Peaks Foot and Ankle, receives from you as our patient. We will use this information to provide caring and quality medical care for you. Examples of PHI include diagnosis treatment and communications, oral and written, and including answering machines, voice mail and e-mail, used for follow-up, appointment scheduling, reminders, and test results reporting. As part of our standard healthcare operations, we may share this information with a facility such as a hospital, laboratory, diagnostic service or healthcare provider to coordinate your treatment plain in the most efficient manner. For insurance carriers, your information will be used for claim submission and to obtain payment for services provided. We will exchange data with your insurance carrier for activities such as confirming your eligibility with the plan, benefit and coverage determinations, and pre-certification/authorization and utilization review. Your information is maintained in our office in our practice management information system. We also maintain information about you in our Electronic Medical Record system (EMR). Four Peaks Foot and Ankle limits access to your PHI to those employee's and business associates who need to know this information and we restrict the types and amount of information provided to the which is "minimally necessary" in order to carry out their work. We do not disclose PHI to third parties for purposes other than treatment, payment or health care operations unless the following exceptions occur:

- We receive a signed authorization from you to release your individually identifiable information. An Authorization from will be signed by you, the patient, or authorized guardian. This authorization will be placed in your medical record. It may be cancelled by you, the patient, or authorized guardian at any time. If you desire limited access or specific individual's access to your PHI, please complete a Request to Restrict Use and Disclosure of Protected Health Information form.
- Federal, state or other applicable law requires us to share PHI
- Workers' Compensation purposes

You have the right to request a review of your PHI, to amend your records, and request restrictions on how your PHI is used. You may request an accounting of how your PHI has been disclosed. Any request for amendments or restrictions to the use of your PHI must be in writing. You have a right to request a copy of your medical record. Four Peaks Foot and Ankle will make every effort to provide you with your record within a reasonable amount of time and subject to normal copying charges. If you have any questions, comments or complaints regarding the management of your PHI, please contact our office and the Practice Manager. If such complaints are unresolved, you have the right to report to the Department of Health and Human Services.

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PATIENT RIGHTS & RESPONSIBILITIES

This practice presents these Patient Rights and Patient Responsibilities to reflect the commitment 10 providing quality patient care, facilitating dialogue between patients, their physicians, and the facility management, and promoting satisfaction among the patients and their designated support person(s), physicians, and health professionals who collaborate in the provision of care. This practice recognizes that a personal relationship between the physician and the patient is an essential component for the provision of proper medical care. When the medical care is rendered within an organizational structure, the practice itself has a responsibility to me patient to advocate for expanded personal relationships and open communications between patients and their designated support persons, physicians and the organization's staff members. This practice has many functions to perform, including but not limited to preventing and treating medical conditions, providing education to health professionals and patients and conducting clinical research. All these activities must be with an overriding concern för the patient and above all the recognition of his or her dignity as a human being. Although no catalogue of rights can provide a guarantee that the patient will receive the kind of, he she has a right to expect, these patient rights are affirmed and actively incorporated into the care provided in this practice.

1. The patient has the right to received considerate and respectful care in a safe setting.
2. The patient has the right to know the name of the physician responsible for coordinating his/her care.
3. The patient has the right to obtain information from his or her physician in terms that can be reasonably understood. Information may include, but is not limited to his or her diagnosis, treatment, prognosis, and medically significant alternatives for care or treatment that may be available. When it is not medically advisable to share specific information with the patient, the information should be made available to an appropriate person in his or her behalf. When medical alternatives are to be incorporated into the plan of care, the has the right to know the name of the person(s) responsible for the procedures and/or treatments.
4. The patient has the right to obtain the necessary information his or her physician to give informed consent before the start of any procedure and/or treatment. Necessary information includes, but is not limited to, the specific procedure and/or treatment. The probable duration of incapacitation, the medicallysignifican risks involved, and provisions for emgerncy care.
5. The patient has the right to refuse treatment to the extent permitted by law. and to be informed of the medical consequences of his or her action.
6. The patient has the right to obtain information about any financial and/or professional relationship that exists between this practice and other health care and educational institutions insofar to his or her care is concerned. The patient has the right to obtain information about any professional relationships that exist among individuals who are involved in his or her procedure or treatment.
7. The patient has the right to every consideration for privacy throughout his or her medical care experience, including but not.limited to, the following. Confidentiality and discreet conduct during case discussions, consultations, examinations, and treatments. Those not directly involved in his or her care must have the permission of the patient to be present. All communications and records pertaining to the patient's care will be treated as confidential.
8. The patient has the right to expect reasonable continuity of care, including, but not limited to the following. The right to know in advance what appointment times and physicians are available and where. The right to have access to information from his or her physician regarding continuing health care requirements following discharge. The number to call for questions or emergency care.
9. The patient has the right to access and examine an explanation of his or her bill regardless of the source of payment.
10. The patient and support person(s) have the right to know what practice rules and regulations apply to their conduct as a patient and guest during all phases of treatment.
11. The patient has the right to be free from all forms of abuse, neglect, or harassment
12. The patient has the right to exercise his or her rights without being subjected to discrimination or reprisal.

Patient Responsibilities

It is the patient's responsibility to participate fully in decisions involving his or her own health care and to accept the consequences of these decisions if complications occur.

It is the patient's responsibility to follow up on his or her physician's instructions, take medications when prescribed. and ask questions that immerge concerning his or her own health care.

It is the patient's responsibility to provide name of support person in case of emergency and have this support person available when advised to do so.

Direct any care concerns or complaints to:
Facility Director: Jeff Jarvie Phone: (480) 931-3887

Department of Health: 250 N. 17th AVE. PHX, AZ 85007 Phone: 602-542-6128
Office of the Medicare Beneficiary Ombudsman Phone: 1-800-MEDICARE (1-800-633-4227)
Website: HTTPS://WWW.MEDICARE.GOV/BASICS/YOURMEDICARE-RIGHTS/GET-HELP-WITH-YOUR-RIGHTS-PRO

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