ASHLEY VALLEY FOOT AND ANKLE, INC.
Jeremy Strange, DPM
75 No. 200 W., Suite #1, Vernal, UT 84078
Phone: (435) 789-2062 Fax: (435) 789-2063

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Sex: o F o M Marital Status: o S o M o D o W

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ E-Mail: _____

Phone #'s Home: _____ Work: _____ Cell: _____

Preferred Language: _____ Ethnicity: o Hispanic or Latino o Not Hispanic or Latino Race: _____

Patient Relationship to responsible party: o Self o Spouse o Child o Other: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Care Physician: _____ Who may we thank for your referral? _____

Patient's Employer: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Accident Information (if applicable): Date: _____ Work related? o Yes o No Auto? o Yes o No Other: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Date of Birth: _____ Sex: o F o M

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ E-Mail: _____

Phone #'s Home: _____ Work: _____ Cell: _____

Employer: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

PRIMARY:

Insurance Company: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

ID Number: _____ Group Number: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Patient Relationship to subscriber: o Self o Spouse o Child o Other: _____

SECONDARY:

Insurance Company: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

ID Number: _____ Group Number: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Patient Relationship to subscriber: o Self o Spouse o Child o Other: _____

Patient Name: _____ Date of Birth: _____

CONSENT AND CONDITIONS OF SERVICE

As either the Patient or the legally authorized representative of the Patient, the following consents, understandings, and agreements are made on my own behalf, or on behalf of the Patient in partial consideration of the health care services to be provided to the Patient by *Jeremy Strange, DPM*; to provide health care services to Patient and to administer physician orders for the benefit of the Patient for this visit and any subsequent visits. It is understood that this consent may be revoked in writing at any time. It is understood that there is risk of substantial and serious harm involved in such health care services, and such risk is accepted in the hope of obtaining beneficial results from such services. No promises of any particular outcome or successful result have been made, it being understood and accepted that there is some uncertainty involved in the outcome of health care services for which this consent is given. It is understood that physicians are separately responsible to explain what they do.

Patient and the undersigned, if other than the patient, each jointly and severally agree to pay for all health care services rendered to Patient from *Jeremy Strange, DPM* including, but not limited to, any amounts not paid by any insurance company or other third party payor. Patient and the undersigned, if other than the Patient, remains responsible for all co-payments, deductibles, co-insurance, and/or non-covered services regardless of amount paid by insurance or third party payor. It is the policy of *Ashley Valley Foot and Ankle, Inc. / Jeremy Strange, DPM* to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. In the event that payment in full for charges incurred was not made, Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay interest at the rate of 18% annually on all past due balances from the original due date, plus court cost and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee if my account is assigned to a collection agency. Furthermore, the Patient or the undersigned, if other than the patient, each jointly and severally agree to pay a *$20.00 billing fee for any co-payments not paid for at the time of service* and to pay a service charge of $20.00 plus any bank charges in connection with any check or other instrument tendered by the Patient or the undersigned but returned unpaid to *Ashley Valley Foot and Ankle, Inc. / Jeremy Strange, DPM*.

I have read the above and accept financial responsibility, in full, for this account.

X _____ _____

Signature of Patient or Legally Authorized Representative Date

AUTHORIZATION FOR ASSIGNMENT - PAYMENT

I, the undersigned, authorize the release of any medical or other information necessary for my insurance to process payment of received services. I also request that payment of authorized Medicare, Medicaid, or health insurance benefits are to be made to ***Ashley Valley Foot and Ankle, Inc. and/or Jeremy Strange, DPM*** for services rendered to myself or to the Patient, if acting as the legally authorized representative of the Patient.

X _____ _____

Signature of Patient or Legally Authorized Representative Date

ACKNOWLEDGMENT OF REVIEW / RECEIPT OF PRIVACY PRACTICES

I, the undersigned, acknowledge that I have been given the opportunity to read the *Privacy Practices*. I understand that ***Ashley Valley Foot and Ankle, Inc.*** takes every precaution to safeguard my *"Protected Health Information" (PHI)*. By signing this acknowledgment I am Consenting to ***Ashley Valley Foot and Ankle, Inc.*** use and disclosure of my *PHI* to carry out treatments, payment, and health care operations. If I do not sign this consent, or later revoke it, ***Ashley Valley Foot and Ankle, Inc.*** may decline to provide treatment to myself, or to the Patient, if acting as the legally authorized representative of the Patient.

X _____ _____

Signature of Patient or Legally Authorized Representative Date

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PAYMENT POLICY

Patient Name: _____ Date of Birth: _____

Thank you for choosing us as your ***podiatry provider***. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

X _____ _____

Signature of Patient or Responsible Party Date

ASHLEY VALLEY FOOT AND ANKLE
Jeremy Strange, DPM

Name: _____ Age: _____

REASON FOR VISIT Check all that apply:

__ Ankle pain __ Athlete's foot __ Bunions __ Corns/Calluses
__ Cramps/Numbness __ Heel pain __ Ingrown nails
__ Warts __ Swelling __ Tired/aching feet __ Injury

Details:

__ Foot __ Ankle __ Right __ Left __ Both

When did it start? _____

Rate your pain: _____ (1 = Least Pain - 10 = Most Pain)

Accident Information (if applicable): Date: ____/ ____/_____

__ Work-related __ Auto-related __ Other: _____

Details:

First visit to a doctor for this problem: _____

FAMILY HISTORY

Has anyone in your family had any of the following?

Check if yes Details: (when, who: parents, siblings, other)

__ Arthritis
__ Birth defects
__ Cancer (type)
__ Diabetes
__ Heart Attack
__ Blood Pressure
__ Osteoporosis
__ Stroke
__ Other

SURGICAL HISTORY

List all surgeries you've had, along with the approximate dates?

MEDICATIONS

Medications, including over-the-counter, you are presently taking:

Please use back of form if additional space is needed.

Signature: _____
(If patient is a minor, signature of Parent or Legal Guardian required)

SOCIAL HISTORY

If female, are you pregnant? __ Yes __ No

Smoking status: __ Never Smoker __ Former smoker

__ Current every day smoker __ Current some day smoker

Packs/day: _____Type: __ Cigarettes __ Cigars __ Chewing Tobacco

Do you drink alcohol? __ Yes __ No

Drinks/day: _____ Type: __ Beer__ Wine__ Hard alcohol

Do you exercise regularly? __ Yes __ No

MEDICAL HISTORY Check those YOU were treated for:

Date of last exam with primary care doctor: ____/ ____/_____

HEART:
__ Rheumatic Fever
__ Murmur
__ Chest Pain
__ Angina
__ Heart Attack
__ Congestive Heart Failure
__ Hypotension
__ Hypertension
__ Heart Disease

SKIN:
__ Lesion(s)
__ Moles
__ Eczema
__ Rashes
__ Cancer

ENDOCRINE:
__ Diabetes
__ Thyroid
__ Dysfunctions
__ Hypoglycemia

GASTROINTESTINAL:
__ Ulcers
__ Hiatal Hernia
__ Reflux
__ Diarrhea
__ Diverticulitis
__ IBS

BLOOD:
__ Anemia
__ Bleeding Tendencies
__ Blood Clots

OTHER:

LIVER:
__ Hepatitis
__ Liver Dysfunction

MUSCULOSKELETAL:
__ Serious Injuries
__ Back Problems
__ Deformities
__ Loss of Strength
__ Joint Pain
__ Osteoarthritis
__ Rheumatoid Arthritis
__ Lupus
__ Cramps

NEUROLOGIC:
__ Depression
__ Weakness
__ Numbness
__ Stroke
__ Seizures
__ Migraines
__ Nervous Condition

LUNGS:
__ Asthma
__ Pneumonia
__ Shortness of Breath
__ Emphysema
__ Pulmonary Embolism

KIDNEYS:
__ Kidney
__ Bladder
__ Prostate Problems

ALLERGIES Check all that apply:

__ Adhesive Tape __ Morphine __ Sulfa Drugs
__ Aspirin __ Penicillin __ Latex
__ Chemicals __ Foods __ Codeine
__ Antibiotics: _____
__ Other: _____

Print Name: _____ Date: _____