JEFF L. HARSCH, D.P.M., F.A.C.F.A.S.
DIPLOMATE, AMERICAN BOARD OF FOOT AND ANKLE SURGERY
FELLOW, AMERICAN COLLEGE OF FOOT AND ANKLE SURGEONS

NEW PATIENT REGISTRATION

Date:________________________

Name:____ Preferred Name:__________________

Mailing Address:____
Number Street Apt#

____
City State Zip Code

Home Phone:______________________ Cell Phone:______________________ Work Phone:______________________

Email Address:____

Date of Birth: _______/_______/_______ SS#:_______-_______-________ Marital Status:_____________ Sex: M / F

Employer/School: ____ □ Full Time □ Part Time □ Retired

If a minor, please designate the financially responsible party:

Name:____ Date of Birth: _______/_______/_______

May we discuss your medical condition with another person? □ Yes □ No

If yes, whom:____ Relationship:________________________

Whom may we thank for referring you? ____

Primary Care Physician:____ Phone:________________________________

Pharmacy Name:_________________________________ Pharmacy Location:__________________________________

Emergency Contact:

Name:____________________________________ Relationship:___________________ Phone:____________________

Primary Insurance:_____________________________

Member ID:___________________________________

Group #:______________________________________

Subscriber Name:______________________________

DOB: _____/_____/_____ SS#:______-_____-______

Secondary Insurance:___________________________

Member ID:___________________________________

Group #:______________________________________

Subscriber Name:______________________________

DOB: _____/_____/_____ SS#:______-_____-______

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CONSENTS

Acknowledgement of Privacy Practices

It is a requirement by state law to offer a copy of our Notice of Privacy Practices to our patients. Should you like a copy of these practices, please request one. By signing below you agree and acknowledge our privacy practices.

____
Patient Signature

Rescheduling and No Show Policy

If you need to reschedule or cancel your appointment, we require you do so at least 24 hours before your scheduled appointment. If you request to have your appointment rescheduled/cancelled twice consecutively, **or** the appointment is missed entirely, a $50 charge will be applied to your account.

____
Patient Signature

Billing Insurance

I authorize my insurance company to pay benefits on my behalf directly to the Foot and Ankle Clinic. Your office has my permission to use my health care information for the purpose of obtaining payment for services, to determine insurance benefits, and for any other purpose not set out in our privacy practices.

____ ____________________
Patient Signature Date

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FINANCIAL POLICY FOR MEDICAL SERVICES

We ask that you present your insurance card at your initial visit and any time there is a change made to your insurance policy. There is always a chance the patient will be financially responsible for all services rendered at the Foot and Ankle Clinic. For example, if we are not a participating provider within your insurance network, if you fail to provide your insurance card, or if you provide the incorrect insurance card. If we have a contract with your plan, we will file all claims with your insurance company.

Please note that even if a procedure is deemed medically necessary and is considered a covered benefit from your insurance company, there may be deductibles or coinsurance amounts due after the claim has been processed and paid by your insurance plan. Once the claim has been completed and paid by your insurance company, you will receive a statement for the remaining balance that you are financially responsible for. If you would like an itemized statement of your visit, please request one and it will be provided to you. We accept cash, checks, MasterCard, Visa, and Discover.

Co-Payment Policy

If there is a specialty copay with your insurance company, we will collect payment at the date those services are rendered. Should you fail to provide payment for your copay, you will be billed for that amount.

Self-Payment Policy

New patients are responsible for an initial office visit of $140. If you are unable to pay for the remaining charges from this initial encounter, the remainder of payable services can be billed to you once a payment plan has been established in office. Payment for the office visit is required each time services are rendered. This is applicable for patients without available insurance information and patients with out-of-network insurance.

Outstanding Balances

A statement will be mailed at the beginning of each month. If no payment has been received within 3 months of the date of service, the remaining outstanding balance will be turned over to our collections company, Kansas Counselors, Inc. All collection fees and court costs will be added to your balance.
If a patient refund is due, the Foot and Ankle Clinic will issue a check once the following criteria have been met:

- You have not been seen in office for 30+ days
- There are no pending insurance claims on your account
- There are no outstanding patient balances on your account

The patient has read and understands the financial policy and agrees to the specified terms therein. This policy will stay in effect as long as you are a patient of the Foot and Ankle Clinic

____ ____________________

Patient Signature Date

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PATIENT HISTORY

Primary Care Physician:________________________________ Date Last Seen:________________________________

Chief Complaint:____

Medical History:

□ AIDS/HIV
□ Alzheimer's Disease
□ Angina/Chest Pain
□ Anemia
□ Arthritis
□ Asthma
□ Bleeding Disorders
□ Cancer
□ Chronic Diarrhea
□ Type 1 Diabetes
□ Type 2 Diabetes
□ Dementia
□ Epilepsy
□ Ear Problems
□ Eye Problems
□ Fainting
□ Gout
□ Headaches
□ Heart Disease
□ Hemophilia
□ Hepatitis
□ High Blood Pressure
□ High Cholesterol
□ Kidney Disease
□ Pacemaker
□ Psychiatric Care
□ Respiratory Disease
□ Rheumatic Fever
□ Stroke
□ Tuberculosis
□ Valve Replacement
□ Joint Replacement
□ Unexplained Weight Loss
□ Other:___________

Family History:

□ Diabetes
□ Heart Disease
□ Cancer

Previous Surgeries	Date Mo/Yr	Previous Hospitalizations	Date Mo/Yr

Medications	Dosage	Medications	Dosage

Allergies:

□ Adhesive Tape □ Aspirin □ Codeine □ Demerol □ Iodine □ Latex □ Local Anesthetics □ Penicillin □ Seafood
□ Sulfa Drugs □ Other:__________ □ No Known Drug Allergies

Social History:

Previous Nicotine Use: □ Yes □ No   Current Nicotine Use: □ Yes □ No
Alcohol Abuse: □ Yes □ No   Drug Abuse: □ Yes □ No