Arizona Foot & Wound Specialists● Sophia Stocks, DPM

Date:_____ Name: _____

Reason for today's visit: _____

Height: _____ Weight: _____ Shoe Size: _____

What treatment methods have you tried? _____

Please indicate if **you** have or had any of the following:

[ ] AIDS/HIV
[ ] Alcohol Abuse
[ ] Allergies to Medicines/Drugs
[ ] Anticoagulant Therapy
[ ] Arthritis
[ ] Artificial Heart Valves or Joints
[ ] Asthma or Respiratory Disease
[ ] Back Problems
[ ] Bleeding Disorders
[ ] Cancer
[ ] Chemical Dependency
[ ] Chest Pain or Angina
[ ] Circulatory Problems
[ ] Diabetes
[ ] Diabetic Foot Wound
[ ] Gout
[ ] High Blood Pressure
[ ] Heart Disease
[ ] High Cholesterol
[ ] Neuropathy
[ ] Kidney Problems
[ ] Liver Disease or Hepatitis
[ ] Phlebitis
[ ] Rheumatic Fever
[ ] Shortness of Breath
[ ] Vascular Disease
[ ] Stroke or Heart Attack
[ ] Thyroid Disease
[ ] Ulcer or Gastritis
[ ] Other:_____

Family History: Please specify family member next to condition: Mother/ Father/ Sibling

[ ] Heart Disease
[ ] Diabetes
[ ] Cancer
[ ] Arthritis
[ ] Vascular Disease
[ ] Neuropathy
[ ] Bleeding Disorder
[ ] Liver Disease
[ ] Circulatory Problems

History of tobacco use: [ ] Yes [ ] No [ ] Quit Years Smoked: _____

Surgeries: _____

Hospitalizations: _____

Family Physician: _____ Ph: (_____)_____ Last Visit Date:_____

Are you now, or have you been under any other doctor's care for any reason over the past two years? [ ] Yes [ ] No
If Yes, please explain: _____

Current Medications/Dosage:_____
_____

Allergies:

[ ] Pain Meds
[ ] Adhesive Tape
[ ] Penicillin
[ ] Aspirin
[ ] Codeine
[ ] Seafood
[ ] Iodine
[ ] Demerol
[ ] Sulfa
[ ] Local Anesthetics
[ ] Novacaine
[ ] Other: _____

Pharmacy Name/Main Cross Streets: _____ Pharmacy Phone: _____

Consent to Retrieve Medication History from Pharmacy: [ ] Yes [ ] No

I certify that the above information 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 treatment of my feet and/ or ankle.

_____ _____
Patient Signature Date

1430 E Missouri Ave, Suite B150, Phoenix, Az 85014
Office: 602-445-6363 ●www.azfootandwound.com● Fax: 602-602-429-8353

Arizona Foot & Wound Specialists● Sophia Stocks, DPM

Date: _____ Name:_____ Date of Birth:_____

Home Ph: (_____)_____ Cell Ph: (_____)_____ Work Ph: (_____)_____

Email: _____ Consent for Reminders Email/Voice: [ ] Yes [ ] No

Preferred Method of Communication: [ ] Phone [ ] Email

Address:_____ Apt/Unit/Suite:_____State: _____ ZIP:_____

SS#: _____ Age:_____ Sex: [ ] Female [ ] Male

[ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Other

Occupation: _____ Employer: _____

Work Address:_____

Primary Insurance:_____ID#_____

Name of Insured:_____Date of Birth_____

Insured's Employer: _____ Relationship to Patient: _____

Secondary Insurance: _____ID#_____

Name of Insured: _____ Date of Birth: _____

Insured's Employer:_____ Relationship to Patient: _____

In case of an Emergency, contact: _____

Phone: (_____)_____ Relationship: _____

Whom may we thank for referring: _____

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____and assign directly to Arizona Foot & Wound Specialists, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize this use of signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date

MEDICARE AUTHORIZATION, if Applicable Please Sign

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Arizona Foot & Wound Specialists, for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in the item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered service. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

1430 E Missouri Ave, Suite B150, Phoenix, Az 85014
Office: 602-445-6363 ●www.azfootandwound.com● Fax: 602-602-429-8353

RELEASE OF INFORMATION AUTHORIZATION
ASSIGNMENT OF BENEFITS FOR MEDICAL PAYMENT OF SERVICES

Authorization for Release of Information: I authorize Arizona Foot & Wound Specialists, to disclose all or any part(s) of the patient's medical record to listed insurance companies and any agency conducting reviews concerning Workers Compensation care.

Medicare Patient's Certification: I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request payment be made directly to the provider of services on my behalf and I authorize said provider to release any and all information necessary regarding the treatment and services provided as stated below.

Assignment of Benefits: I hereby authorize payment directly to Arizona Foot & Wound Specialists, by my insurance company(s). In the event an overpayment is made from more than one insurance company, I understand the overpayment will be sent to the appropriate payer.

Insurance: Arizona Foot & Wound Specialists, will file your insurance as a service to you. If our office does not hear from your insurance company within 60 days, we will request your help in contacting your insurance company to resolve the payment delay. The insurance plan is a contract between you and your insurance company. We must hold you responsible for any balances due.

Payment of Services: I understand that I am financially responsible for all charges and fees related to the services rendered to me by Arizona foot & Wound Specialists. I further understand that payment in full is expected upon receipt of the first statement which may include co-payments, deductibles, and any services not covered by my insurance. I also understand that I am financially responsible for any charges not covered by my insurance. I hereby assign to Arizona Foot & Wound Specialists, all benefits I am entitled to receive from any person, insurance company, or entity to the extent of medical charges incurred by the patient or me and authorize payment of such benefits directly to Arizona Foot & Wound Specialists. In the event my account is referred to a collection agency, I will be responsible for collections costs, including interest and reasonable attorney fees.

Health Insurance Portability and Accountability Act (HIPPA): I acknowledge that a copy of the HIPPA Notice of Privacy Practices was made available to me. I was given the opportunity to view a copy of the Notice, which describes how health information about me may be used, disclosed, and how I can get access to this information. If you complete forms prior to your office visit, please see the front desk upon arrival to obtain a copy of this document.'

Valuables: I (we) understand that Arizona Foot & Wound Specialists, is not responsible for valuables and personal property brought to the facility.
I further acknowledge and grant to Arizona Foot & Wound Specialists, a lien pursuant to A.R.S Section 33-932 et seq. Against any recovery by me or any person on my behalf made against an liability, uninsured/ underinsured motorist or other form of coverage or indemnity, or against a person or entity legally responsible for the medical charges incurred to the extent such charges are not paid in full by other available insurance for by me. Arizona Foot & Wound Specialists, and I also waive any attorney's fees or collection costs associated with the collection of medical charges pursuant to the lien hereby granted.

I CERTIFY I HAVE READ AND FULLY UNDERSTAND ALL OF THE ABOVE INFORMATION TO INCLUDE THE CONSENT FOR TREATMENT, RELEASE OF INFORMATION, INSURANCE AUTHORIZATION, & ASSIGNMENT AND PAYMENT OF SERVICES.

_____	_____	_____
PRINT PATIENT NAME	PATIENT/GUARANTOR SIGNATURE	DATE

PRIOR AUTHORIZATION POLICY

It is the responsibility of our insured patients to be aware of any restrictions or requirements stated in their insurance policy. This includes deductibles, second opinions, policy exclusions or waived benefits, precertification, inpatients vs. outpatient benefits, and restrictions regarding pre-existing conditions.

As a COURTESY, our office policy is to contact your insurance company for pre-authorization. However, a pre-authorization issued by your insurance company simply means that they agree that your office visit, medication, surgery, physical therapy or orthotics is medically necessary, though they can reverse this decision once the claim is received. This is a standard disclaimer that all insurance companies tell us when we obtain prior authorization for your medical need What this means is that:

Prior-authorization or precertification does NOT guarantee payment from your insurance company. The patient is ultimately responsible.

Your insurance benefits and the payment we receive are determined by the limits your insurance carrier sets.

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE BENEFITS AND LIMITS.

A deposit may be required, if you have not met your deductible or out of pocket expense.
By signing below, I understand that I am responsible for the charges not covered by my insurance.

_____	_____	_____
PRINT PATIENT NAME	PATIENT/GUARANTOR SIGNATURE	DATE

HEALTH CONTRACT

By seeking podiatric medical advice and treatment by Arizona Foot & Wound Specialists,
I _____(patient name) agree to adhere to treatment recommendations placed forth by my treating podiatric physician. Following treatment protocols are important for treatment success and addressing podiatric pathology. If repeated non-adherence to treatment and recommendation protocols occur,
I _____(patient name) agree for my treatment to be discontinued and forfeit my ability to be treated by the physicians at Arizona Foot & Wound Specialists and will hold harmless Stocks Podiatry LLC (DBA: Arizona Foot & Wound Specialists) for no longer providing me care and I will seek my own podiatric specialist. It is at the discretion of the clinic to provide alternative podiatric specialists for coordination of care.

_____	_____	_____
PRINT PATIENT NAME	PATIENT/GUARANTOR SIGNATURE	DATE

PATIENT FINANCIAL OBLIGATION AGREEMENT

I,_____, UNDERSTAND THAT I AM OBLIGATED FOR THE FOLLOWING:

_____ CO-PAYS AND DEDUCTIBLES AT THE TIME OF MY APPOINTMENT(S).
(INITIAL)

_____ $45.00 CHARGE FOR ANY MISSED APPOINTMENT(S) AND/ OR APPOINTMENTS WHICH
(INITIAL) ARE NOT CANCELLED 24 HOURS PRIOR TO MY SCHEDULED APPOINTMENT TIME.

_____ $20.00 RETURNED CHECK FEE
(INITIAL)

_____ $20.00 LATE FEE IF MY PATIENT BALANCE IS 60 DAYS PAST DUE.
(INITIAL)

_____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

_____
DATE