Total Foot & Ankle Center, LLC
Dr. Glenn C. Woodley

3355 Lake Ariel Highway
Honesdale, PA 18431
Phone: (570) 228-2990
Fax: (833) 989-2249

PATIENT REGISTRATION FORM

Every page must have a signature

Acceptable identification is the following: driver license, passport, government ID, military ID.
You will <u>not</u> be seen without proof of identification or completed forms and signatures
(Please fill out each item or put N/A)

Name: Mr. Mrs. Dr. Ms. _____

Driver License [# and State] _____

Sex:_____Date of Birth:_____Home # _____

Cell #_____Work #_____

Email Address:_____

(essential for patient/doctor secured communication, appt reminders, portal communication; no junk mail or emails)

Local Address:_____

Billing Address: _____

Insured's Name/Date of Birth if different from above: _____

Emergency Contact Name:_____Phone:_____

Personal Physician Name: _____

Physician Address / Phone Number: _____

How did you hear about us? (please circle) Google Billboard Radio Word of Mouth Doctor Newspaper Other

Please specify: _____

If patient is a minor, name of person responsible for payment: _____

Address (if different from above): _____

I hereby give permission to Dr. Glenn Woodley, and/or his associates of Total Foot & Ankle Center, L.L.C. (TFAC) to administer treatment and to perform such procedures, tests, labs as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. I also hereby assign to the above-named physicians, and TFAC all benefits provided by my insurance company policy or policies for medical or surgical care. **I understand that I am financially responsible for any balance due on my account and a collection agency will be employed to enforce such.** Furthermore, **I have read and signed the financial responsibility form and understand the financial policy of the Total Foot & Ankle Center, L.L.C. This is a lifetime signature.**

As our physicians are only fluent in English, it is the responsibility of the patient to provide an interpreter over the age of 18 if the patient will be unable to speak with and understand the physicians. This is necessary for us to render medical care and for the protection of the patient.

Privacy and Information Protection Policy

Our office utilizes a HIPAA compliant Electronic Medical Record Storage system. All data collected on this form is strictly used for insurance claim purposes and never shared with outside sources. All information not stored in the secured electronic storage format are shredded and disposed of properly. **By signing below, you are acknowledging that you have either received a copy of our Privacy Policy or have been given access to a copy to review.**

It is understood that all Durable Medical Equipment & products including, but not limited to, creams, lotions, orthotics, arch supports, braces, pads, diabetic shoes, surgical shoes, crutches, can be purchased via an outside professional vendor. The products and in-office dispensing are for our patients' convenience; financial responsibility will be solely on the patient. All payments for such services or devices are due upon the receipt of service or item unless other arrangements have been made in advance.

Signature of Responsible Party_____**Date** _____

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Podiatric Medical History

THIS IS INFORMATION IS ***REQUIRED*** FOR THIS OFFICE AND ***MUST BE SUPPLIED***

YOU WILL NOT BE SEEN WITHOUT THIS INFORMATION FILLED OUT

What is your foot or lower leg complaint? _____

For how long have you had it?_____Pain level (0 = no pain, 10 = extreme pain) _____

What aggravates this? _____

What helps this problem? _____

More pain -- [ ] in the morning or [ ] end of the day

Have you ever been treated by a podiatrist or orthopedist? [ ] YES [ ] NO

Name and Address _____

If yes, list treatments rendered _____

***** Please Note: IF YOUR VISIT IS DUE TO AN INJURY, BRIEFLY DESCRIBE THE EVENTS SURROUNDING THE OCCURANCE (Where? What activity were you doing? Etc.)**

_____

_____

_____

Other Medical Problems

Tobacco (Yes / No) If yes, how many packs per day; If yes, for how many years: _____

Alcohol (Yes / No) If yes, how frequent:_____; Occupation: _____

Have you ever completed an Advance Directive?_____

Food/Drug Allergies: _____

What Pharmacy do you use?_____ Store# and Phone#_____

Did you complete the information through the patient portal? [ ] YES [ ] NO

Medications (include herbal and over-the-counter medications or attach list) _____

_____

_____

Medical Problems _____

_____

Have you ever tested positive for infectious diseases such as Hepatitis or HIV? [ ] YES [ ] NO

Prior Surgeries and Dates: _____

_____

Family History of [ ]Diabetes [ ]Hypertension [ ]High Cholesterol [ ]Thyroid [ ]Cancer [ ]Other:

_____

Signature_____ Date _____

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FINANCIAL POLICY

PLEASE SIGN APPROPRIATELY BELOW

We are committed to providing you with the best possible care. We are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is required at the time services are rendered. We accept payment in the form of cash, check, MasterCard, Visa, American Express, or Discover. If you have insurance coverage that we do not participate with, we will process a claim *after* you have paid in full any balances due. Returned checks and balances older than 60 days are subject to additional collection fees and interest of 1.5% per month. ***Balances older than 60-days are forwarded to a collection agency.***

Please realize that:

1. **Medicare patients**: We would like you to understand that taking assignment means that YOU are responsible for the yearly deductible determined by Medicare and for the 20% (coinsurance) of what Medicare allows. You are also responsible for services that your coinsurance doesn't cover. We may ask you to sign a **Medicare Advanced Beneficiary Form (ABN)**, which states that if Medicare does not cover a service or medical equipment, you understand that you will be responsible for payment.
2. The filing of **SECONDARY INSURANCE CLAIMS** is a COURTESY that we extend to our patients. We will make every effort to help you in the filing of your claims; however, all charges are ultimately YOUR responsibility after the initial filing with your insurance company. We realize that temporary financial problems may affect timely payment of your account. We encourage you to contact us *promptly* for assistance in the management of your account.
3. I agree that if **my account falls delinquent**, I will be responsible for all collection costs, including but not limited to the outstanding balance, attorney fees, court costs, collection agency fees and interest from the date of service at the rate of 1.5% per month [18% annum]
4. I authorize Total Foot & Ankle Center, L.L.C. to submit all insurance claims on my behalf. I understand that I am responsible for all services not paid in full within 60 days of service, regardless of the reason given by the insurance company.
5. We are not in Network with most HMO.

****There is a $25.00 charge to the patient for the completion of forms (insurance, disability, etc.).**
****Medical Record Fees are $1.00 per page for the first 25 pages and 25 cents for each additional page.**
****There is a potential $100.00 charge for patients who have an appointment but "no call/no show" 2 times**
****Return Policy: Items purchased have a refund policy of 14 days. The item is to be unused and unopened to receive full refund.**

A) NON-PARTICIPATING AND SELF-PAY STATUS – SIGN BELOW

We are not participating with every insurance company available. If you are not sure if we are participating, we encourage you to call your insurance company to verify our participation. **Ultimately, it is your responsibility to know your policy**. For insurance companies that list us as non-participating or non-preferred providers, **our office policy is to collect the full price of the visit up front**. We will extend the courtesy of filing with your insurance on your behalf after payment of all services rendered**. Any questions about pricing should be addressed *prior* to treatments being rendered.**

Signature and Date _____

B) PARTICIPATING INSURANCES AND MEDICARE ASSIGNMENT -- SIGN BELOW

I authorize payment of MEDICAL BENEFITS be made on my behalf to Total Foot & Ankle Center, L.L.C., for any services furnished to me. I authorize the release of any medical information held by the Total Foot & Ankle Center, L.L.C. to the health care financing administration and its agents in order to process my claims.

Signature and Date _____

C) POLICY ON MEDICAID (FOR MEDICAID PATIENTS ONLY) – SIGN BELOW

We participate on a limited basis with Pennsylvania Medicaid. All Medicaid patients will be treated as self-pay patients *except* as secondary payer to Medicare, children 17 years old or younger or seen as a first time patient in the hospital.

Signature and Date _____

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CONSENT FOR COMMUNICATION AND/OR DISCLOSURE

I request the following alternatives or limitations relating to communication directed to me by my healthcare provider or employee of Total Foot & Ankle Center. I understand that HIPPA consent applies to ALL providers of Total Foot & Ankle Center. It is my responsibility to notify Total Foot & Ankle Center of any changes.

Do we have permission to leave the following information on voicemail?

___Billing ___Medical

Preferred Phone Number:_____

Would you prefer to use the Patient Portal as your preferred method of communication?

___Y ___N

_____ _____
Signature Date

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PROTECTED HEALTH INFORMATION FORM

AUTHORIZATION TO SHARE "PROTECTED HEALTH INFORMATION" (P.H.I.)
PURPOSE: To permit Total Foot & Ankle Center to share personal health information with persons other than the patient's name below:

Section I: [Please print]

TFAC Patient's Name_____Date of Birth _____

Section II: Please identify the person(s) with whom your information may be shared and their relationship with you. Please print. If none, write NONE

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship _____

Section III: This authorization will expire ***only*** upon receiving written notification from me.

Acknowledgment: I, hereby, permit Total Foot & Ankle Center to share the following "protected health information" concerning me:

- Health information concerning appointments; all past, present, and future health information
- Any and all laboratory results and other diagnostic results (e.g., x-ray, bone scan, ultrasound, etc.)
- Confirmation of appointment details

I understand that my "protected health information" may be shared with the people listed above, and that they may not be required to comply with federal health information privacy laws. I understand that the practice reserves the right to deny access. In addition, authorized individual(s) must present identification as proof that they are who they claim to be.

_____ _____
Signature Date