Patient Registration Form

LEVICK FOOT&ANKLE INSTITUTE

Patient Information

Name _____ Biological Gender ◯ Male ◯ Female

Date Of Birth _____

Age _____ Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Minor

Phone Number Home: _____ Cell: _____ Work: _____
(circle preferred method of contact)

Home Address _____ **City:** _____ **Zip:** _____

Email _____ **Height** _____ **Weight** _____

Reason for Visit? _____

Pharmacy Name, Address and Phone _____

New Patient? ◯ Yes ◯ No If returning, when was your last appointment? _____

Emergency Contact Information

Name _____ Relationship _____

Phone Number _____ Email _____

Primary Care Physician _____

Phone Number _____ Address _____

Employment Information

Current Employer _____ Phone _____

Employer Address _____

Occupation _____

Insurance Information

Primary Insurance Company _____

ID # _____ Group # _____

Policy Holder Name _____ Policy Holder DOB _____

Relationship to Patient _____

Secondary Insurance Company _____

ID # _____ Group # _____

Policy Holder Name _____ Policy Holder DOB _____

I certify that I have insurance coverage stated above and assign directly to Dr.Lisa Levick all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Patient's Signature ***Date***

Referral Information

Were you referred to our practice? ◯Yes ◯ No | If yes, by whom? _____

Past Medical History

___Arthritis
___Asthma
___Blood Clots
___Depression/Anxiety
___Diabetes Type I
___Diabetes Type II
___Excessive Bleeding
___Thyroid Disease
___HIV/AIDs
___High Blood Pressure
___Joint Replacement
___Kidney Disease
___ Anemia
___ Angina
___ Back Problems
___Cancer
___ Epilepsy
___ COPD
___ Heart Disease
___Gout
___ Neuropathy
___ Hepatitis/Liver
___Peripheral Vascular Disease
___ Psychiatric Care
___ Other _____

Podiatric History

___Athlete's Foot
___Ankle Pain
___Arthritis
___Bunion
___Corns or Calluses
___Cramps in Legs
___Flat Feet
___Hammer Toes
___Heel Pain
___Ingrown Toenail
___Numbness in Feet
___Plantar Warts
___Swelling

Family History

Mom/Dad?

___ Alcoholism_____
___ Arthritis_____
___ Asthma_____
___ Breast Cancer_____
___Cancer_____
___Diabetes_____
___Heart Disease_____
___Hypertension_____
___High Cholesterol_____
___ Kidney Disease_____
___Smoking_____
___Stroke_____

Diabetic History

Are you Diabetic?: Y N For How Long?_____
Fasting Blood Glucose Today? _____
Last A1C? _____ Date: _____
Last Time You Saw your PCP _____
Endocrinologist_____
History of Ulceration/Infection? Y N
History of Leg Stent? Y N

Social History

Current Smoker? Y N For How Long?_____
Past Smoker? Y N Quit Date? _____
Alcohol? Y N Daily__ Occasional__ Special Occasion__
Vape? Y N
Marijuana? Y N Smoke_____ Gummies_____
Exercise? Y N
Other:_____

Surgical History

Date:_____Procedure:_____Surgeon:_____
Date:_____Procedure:_____Surgeon:_____
Date:_____Procedure:_____Surgeon:_____
Date:_____Procedure:_____Surgeon:_____
Date:_____Procedure:_____Surgeon:_____

Current Medications

Name:_____ Dose:_____ Qty:_____ How often:_____
Name:_____ Dose:_____ Qty:_____ How often:_____
Name:_____ Dose:_____ Qty:_____ How often:_____
Name:_____ Dose:_____ Qty:_____ How often:_____
Name:_____ Dose:_____ Qty:_____ How often:_____
Name:_____ Dose:_____ Qty:_____ How often:_____
Name:_____ Dose:_____ Qty:_____ How often:_____

Currently Pregnant?

Y N

Currently Breastfeeding?

Y N

Allergies

___ NONE
___ Acetaminophen
___ Ampicillin
___ Aspirin
___ Beta Blockers
___Cephalexin
___ Ciprofloxacin
___Codeine
___Erythromycin
___Ibuprofen/NSAIDS
___Morphine
___ Penicillin
___ Steroids
___ Sulfa Drugs
___ Tetracycline
___ Lidocaine/Bupivicaine
___ Dairy
___ Eggs
Other _____

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of any changes in my health, medication, or insurance information.

PATIENT NAME PRINTED_____
PATIENT/GUARDIAN SIGNATURE_____
DATE _____

HIPAA COMPLİANCE PATİENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐ YES ☐ NO
May we leave a message on your answering machine at home or on your cell phone? ☐ YES ☐ NO
May we discuss your medical condition with any member of your family? ☐ YES ☐ NO
If YES, please name the members allowed:

This consent was signed by:_____
(PRINT NAME PLEASE)

Signature:_____ Date:_____

Witness:_____ Date:_____

Levick Foot & Ankle Institute Financial Policy

Copayments, coinsurance, and all applicable deductibles are due at the time services are rendered. We accept cash, check, Visa, MasterCard, Discover and American Express. If you have medical insurance, Levick Foot & Ankle Institute will submit claims directly to your insurance company. Your insurance is a contract between you, your employer and the insurance company. Levick Foot & Ankle Institute is not a party to that contract. Not all services are a covered benefit with all contracts, and it is your responsibility to be aware of what benefits your insurance entitles you to. We will assist you to receive your maximum allowable benefits. We emphasize that as medical care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility. As the guarantor and/or patient, you agree to pay any balance that becomes patient responsibility upon receipt of a statement. **You must pay your statement in full within 30 days from the issue date of the statement. Credit cards on file will be charged the entire amount if not paid within those 30 days with the exception of orthotics which are due in full at time of dispense.**

We reserve the right to implement a service fee of $75.00 for all appointments missed or cancelled without a 24 hour notice.

Deductibles and co-pays are collected at the time of your visit. Self-Pay Patient payments due at time of visit.

In the event your insurance provider denies any portion of your claim, you will be financially responsible for the full amount not covered. Payment will be automatically charged upon receipt of non coverage. It is the patient's responsibility to contact their insurance company directly to appeal or dispute any denied claims.

Workman's Comp is accepted, but the patient must have a claim number, adjuster number, phone number and acceptance letter to see Levick Foot & Ankle Institute before booking appointment. The Practice will accept only the initial insurance information provided and will not switch plans mid-treatment per Federal Law.

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. You must inform the office of all insurance changes and authorization/referral requirements. In the event that the office is not informed, you will be responsible for any charges denied.

There are certain elective surgical and non/surgical procedures that we require pre-payment. You will be informed in advance if your procedure falls into this category. Payment is due prior to the services being performed. I understand that if I do not abide by the financial agreement as noted above, that any balance not paid within 90 days from the date that the balance becomes my responsibility, Levick Foot & Ankle Institute will turn my account over to a collection agency and I will be responsible for all collection and legal fees that the Practice incurs as a result. Levick Foot & Ankle Institute reserves the right to refuse service to any patient that has been placed into collections.

I agree and understand all the above statements regarding financial arrangements and insurance. I authorize Levick Foot & Ankle Institute to submit my claims and remit insurance payment of medical benefits directly to Levick Foot & Ankle Institute.

Name of Patient/Guarantor if Minor_____

Authorization Signature_____Date_____

Signature is required for acknowledgement/receipt of financial policy and insurance/patient billing authorization

Patient Credit Card on File Agreement

Levick Foot and Ankle Institute has implemented a new credit card policy. We kindly request our guardian/guarantor for a credit card which may be used later to pay any balance due on your account.

Co-pays, deposits, and fees for non-covered services are still due at the time of service.

At registration and/or check-in, your credit card information will be obtained and kept securely until your insurance has paid their portion and notifies us of the balance due. If any period at that time, you will be sent a statement, in which you will have 30 days to pay. After 30 days, and if the bill remains unpaid, we will charge the authorized credit card. A receipt for that charge will be sent to the e-mail on file.

If you have any questions about the card on file payment method, please do not hesitate to let us know.

By signing below, I authorize Levick Foot and Ankle Institute to keep my signature and credit card information securely on file in my account. I authorize Levick Foot and Ankle Institute to charge my credit card for any outstanding balances when due. These balances could be, but are not limited to copayment, deductible, coinsurance, non-covered services, or payer claim denials. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form. I also understand that it is my responsibility to update the credit card and notify Levick Foot and Ankle Institute when the credit card expires or changes for any reason. I understand that I will not be seen as a new patient if I decline to have a credit card on file.

☐ VISA ☐ Mastercard ☐ AMEX ☐ Discover

Name on Credit Card_____

Credit Card #_____

Expiration Date_____ CVV_____

Zip Code_____

Patient/Guarantor Signature Date

Frequently Asked Questions Regarding the Credit Card on File Agreement

Do I have to leave my credit card information to be a patient at this practice?
Yes. This is our policy, and it is a growing trend in the healthcare industry. Insurance reimbursements are declining and there has been a large increase in deductible/ Co insurance/ co-pay abortions. These factors can drive offices to see more patients for shorter periods of time or in some cases to stop accepting insurance altogether. We have decided to focus on becoming more efficient in our billing and collections processes instead.

How much and when will money be taken from my account?
The insurance companies take approximately 2 to six weeks to process submitted claims. Whatever the allowed amount is, your copay, and coinsurance, and deductible are taken into consideration. What you may owe depends on your individual policy. Once the insurance explanation of benefits is received/ posted to your account and electronic statement will be generated and sent to you showing your portion. You will have 30 days to send an alternative form of payment if you prefer.

How do you safeguard the credit card information you keep on file?
We use the same methods to guard your credit card information as we do for your medical information. Card information is securely protected by the credit card processing component of our HIPAA compliant practice management system and credit card manager. This system stores the card information for future transactions using the same sort of technology that any online retailer would. Once in the vault, there is no way to transfer the data. There is no way to export the card information out of our system. The sheet you fill out will be shredded once uploaded.

What if there is a payment discrepancy or I have other payment questions?
Please contact our billing department directly to settle payment discrepancies or for other payment questions period this policy in no way compromises your ability to dispute a charge or questions your insurance companies explanation of benefits.

Will I receive a paper bill by mail?
Yes. You will receive one statement which will show what you will be charged to your card in 30 days. If you prefer to pay by an alternative method, you may do so during that time. If you do not wish to make any payment method changes, just hold on to the statement for your records and your card will be charged.