WASATCH
FOOT & ANKLE INSTITUTE

First Name: _____ Middle Initial: _____Last Name: _____

D.O.B.: _____Sex:___M/F___Email: _____

Address: _____ City: _____ Zip: _____

Home Phone:(___)_____ Cell Phone: (___)_____ Work Phone: (___) _____

Preferred Language: _____ Race: _____ Ethnicity: _Hispanic / Non-Hispanic__

Marital Status: _____ Employment Status: _____

Primary Doctor: _____ Pharmacy:_____

Insurance Holder Name: _____ Relation to Patient:_____

D.O.B. :_____ Check here if self:_____

Emergency Contact: _____

Relation to Patient: _____Phone Number: (___) _____

Primary Caregiver/ Legal Guardian: _____

Relation to Patient:_____Phone Number: (___)_____

Medical Record Release Form

I, _____ hereby authorize the release of information as indicated:

My Healthcare Information
I authorize disclosure of healthcare information related to my medical history, diagnosis, treatment, or prognosis to all inquiries or only to the following people or entities:

List Names:	Relationship:
_____	_____
_____	_____

I choose Option _____ on the ABN form.

By signing this, I acknowledge and understand the Notice of Privacy Practice, Lifetime of Benefits, ABN, and Medical Record Release.

Signature: _____ Date: _____

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Name: Medical History

- ☐ Anemia
- ☐ Angina
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Balance Problems
- ☐ Blood Clots
- ☐ Cancer (Specify Type)
- ☐ Cerebrovascular Accident
- ☐ Chemotherapy
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Fractured Foot, Ankle, or Leg
- ☐ GERD
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Leg Cramps
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Nervous Disorder
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Peripheral Neuropathy
- ☐ Peripheral Vascular Disease
- ☐ Plantar Fasciitis
- ☐ Psychological Problems
- ☐ Raynaud's Syndrome
- ☐ Renal Dialysis
- ☐ Rheumatoid Arthritis
- ☐ Varicose Veins
- ☐ Women: Are you pregnant?

If you drink alcoholic beverages, please list how often: _____

Do you smoke? Yes/No If yes, how often? _____

Prior Operations: _____

_____

Medication Allergies: _____

Please list all Medications you take and dosage (or attach a list):

_____ _____

_____ _____

_____ _____

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Summary of Notice of Privacy Practices

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization.

- To family members or close friends who are involved in your health care and are approved by you
- For purposes of public health and safety
- To government agencies for purposes of their audits, investigations, and other oversight activities
- To government authorities to prevent child abuse or domestic violence
- To the FDA to report product defects or incidents
- To law enforcements authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas, and as otherwise required by law.

Patient Rights. As our patients, you have the following rights:

- To have access to and/or a copy of your health information
- To receive an account of certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence
- To request that we amend your health information
- To receive notice of our privacy practices

If you have a question, concern, or complain regarding our privacy practices, please refer to the Notice of Privacy Practices for the person or persons whom you may contact.

Lifetime Assignment of Benefits

I (we) hereby certify that the above information is correct to the best of my knowledge and give permission for Wasatch Foot & Ankle Institute or assistants to examine and treat my ailments medically, surgically, or orthopedically as the case may be.

I (we) also authorize the release of any information including the diagnosis and records of any treatments or examination rendered, to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the doctor, of insurance benefits under which I am entitled.

I (we) hereby authorize Wasatch Foot & Ankle Institute to (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated during examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of the policy lifetime. This order will remain in effect until revoked by me in writing.

I further understand that fees are due and payable on the date that services are rendered, and I agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Your insurance is a contract between you and your insurance company. Any unpaid balance on your account after 90 days from the date of service is your responsibility and rebilling fees of 1 ½% per month (18% annual rate) with a minimum charge of $4.00 per month will be charged to your account. 40% of the balance due and reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection will also be charged to your account.

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Patient Name:

Advance Beneficiary Notice of Non-covered (ABN)

NOTE: If your insurance doesn't pay for services below, you may have to pay.

Your insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance may not pay for the services below.

Services:	Estimated Cost:	Reasons your insurance May Not Pay:
○ CAM Boot (L4360) ○ Plantar Fas. Sleeve (L1902) ○ Ankle Brace (L1906) ○ Night Splint (L4396) ○ Post-Op Shoe (L3260) ○ Bunion Splint (L3100) ○ Crutches (E0110)	$100.00 $15.00 $50.00 $75.00 $25.00 $20.00 $40.00	Your insurance company usually does not pay for this service. Your insurance does not usually pay for this many treatments or services. Your insurance does not pay for this because it is treatment that has yet to be proved effective (expeirmental).

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the services listed above.

Note (For Medicare): If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want at least one of the services listed above. You may ask to be paid now, but I also want my insurance to be billed for an official decision on payment, which is sent to me on Insurance explanation of benefits). I understand that if my insurance doesn't pay, I am responsible for payment, but **I can appeal to my insurance** by following the directions from my insurance company**.** If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want at least one of the services listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance is not billed**.

☐ **OPTION 3.** I do not want any of the services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my insurance would pay.**

Additional Information:

This notice gives our opinion, not an official insurance decision. If you have other questions on this notice or insurance billing, call the number on the back of your insurance card for more details.

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date: