Trinity Foot & Ankle

New Patient Intake Form

_____ _____ _____ _____
First Name **Middle Name** **Last Name** **DOB**

Sex (circle one): Male Female Prefer not to answer

Race (circle one): American Indian/Alaskan native Asian Black/African American Native Hawaiian or Pacific Islander White Other_____ Decline to specify

Ethnicity: Hispanic or Latino Non-Hispanic or Non-Latino Other _____

_____ ___ _____
SSN

_____ _____ _____ _____
Street Address **City** **State** **Zip Code**

Marital Status (circle one): Single Married Widowed Divorced Separated Other

Pregnant (circle one): Yes No Unknown

_____ _____ _____
Occupation **Employer Name** **Employer Phone**

_____ _____ _____
Home Phone **Cell Phone** **Email**

Contact Preference (circle one): Email Phone Text Postal Mail

_____ _____
Emergency Contact Name (First & Last) **Emergency Contact Phone**

_____ _____
Insurance Name (or present card to staff) **Insurance ID#**

Relationship to insured (circle one): Self Spouse Dependent Other_____

Trinity Foot & Ankle

How were you referred to us (circle one): Ad Google Bing/other search engine Postal Mail

Referring Provider Email Walk-in Friend_____ Other_____

_____ _____ _____

Primary Care Physician(PCP) **PCP Phone** **Date of last visit with PCP**

_____ _____

Preferred Pharmacy Name & Location **Pharmacy Phone**

Health Questionnaire

Primary reason for visit: _____

Duration of Condition: _____ What helps?_____

Is it limiting your activity level? Yes No

Secondary Problems: _____

Drug Allergies: _____

Current Medications:_____

Medical History (circle any that apply):

None of the these

ADHD Alzheimers Anemia Anxiety

Arthritis Asthma Back/neck pain Bleeding disorders Cancer Chest Pain Chronic skin infections

Clotting disorders CHF COPD Crohn's disease

Diabetes 1 Diabetes 2 (insulin) Diabetes 2 (non-insulin) DVT/Blood clots

Emphysema Epilepsy Eye condition Fibromyalgia

Gout Headaches Hearing disorder Heart Attack

Heart disease Hepatitis Hepatitis B Hepatitis C

High Blood Pressure High Cholesterol HIV Hypertension

Irritable bowel syndrome Keloid/thick scar Kidney disease Kidney failure

Kidney infections

Liver disease Lung disease Lyme's disease Multiple Sclerosis

Neuropathy Osteoporosis Pacemaker Palpitations/Arrhythmia

Parkinson's disease Phlebitis Poor circulation Prostate cancer

Prostate enlargement Psychiatric disorder Recurrent urinary tract infection

Reflux/heartburn Rheumatic fever Rheumatoid arthritis Sciatica

Seizure disorder Shortness of breath Stomach ulcer Stroke/TIA

Thyroid problem Tuberculosis Ulcerative colitis Vascular disease

Weight loss/gain

Other_____

Have you ever had cancer? Yes No

If yes, what type and what form of treatment? _____

Past Surgeries:_____

Is this problem related to a Workman's Comp injury or auto/other accident? Yes No

Social History

Do you drink alcohol? Daily Regularly Occasionally Rarely Never

Do you smoke, vape or use chewing tobacco? Daily Regularly Occasionally Rarely Never

Do you have/have had a substance abuse problem? Yes Past Never

Family History (circle all that apply):

Diabetes Stroke Cancer Arthritis Heart Attack Hypertension/High Blood Pressure

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- ## PAYMENT RESPONSIBILITIES

We are pleased to welcome you to our office. New Patients are always appreciated. Our practice has grown as a result of its excellent relationship with our referring doctors and patients. As our patient, please feel free, at any time, to express any concerns or to ask any questions that you may have for the doctor or our staff. In order to assist you in making payment(s) for your podiatric treatment, the following options are listed. Please read them carefully and feel free to discuss them with us.

If you DO NOT have insurance: Payment is due, in full, at the time treatment is provided.

*For your convenience, we accept all major credit/debit cards and cash. We accept personal checks for payments under $50.00.

If you have Insurance: The percentage of coverage by your insurance company may be based on your insurance company's own reduced fee schedule for medical services and may be less than actual charges resulting in lower coverage for you. Trinity Foot & Ankle Center has no control over this situation. *Lower payment is a direct result of the plan selected by you or your employer.* **Please be advised that we cannot waive co-payment. We are required by law to collect co-payment.**

Commercial Insurance: We will submit your claim to your insurance carrier for you. You are responsible for any deductible or co-payment not covered by your insurance. Once our office has received payment from the insurance company, you will be billed, with 30 day terms, for any amount still owed. You may choose to keep a credit card on file for those balances left to you by your insurance company.

Medicare: This office accepts Medicare assignment. Medicare patients are fully responsible, however, for the initial yearly deductible and the 20% co-insurance. Federal law requires that physicians collect this amount. If you have a secondary insurance to cover the 20%, we will submit the balance to that insurance for payment and you will only be responsible for the yearly deductible.

_____ _____

Signature of Responsible Party **Date**

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Consent for Treatment and Acknowledgement of Policies

For any insurance plan that requires authorization from a primary care physician (e.g. HMO, PPO, etc.) it is your responsibility (as patient or guardian) to be sure that this office receives all necessary referrals or authorizations PRIOR to treatment. Professional services are rendered and billed directly to your insurance carrier; however you, the patient/guardian, are directly responsible for services rendered by the doctor. A health insurance policy is a contract between you (the patient or subscriber) and your insurance carrier. You MUST notify this Office of any changes to your insurance policy including policy termination, changes in co-payments or a new insurance policy. If for any reason the insurance carrier denies charges, payments for any services rendered will become the responsibility of the patient/guardian. (Initial) _____ I Agree(*)

All office visit charges and co-pays are due at the time services are rendered. It is the patient who is responsible for any and all financial aspects of services rendered. There will be a charge for returned checks, missed appointments without 24 hours notice and completion of any forms. I agree to pay for all deductibles, co-pays, non-covered services and any portion of covered services not paid in full by my insurance plan and understand that such payments are due at the time of service or immediately upon presentation of the bill. I hereby name Trinity Foot & Ankle (TFA) as my assignee. I instruct my health care benefits plan administrator, i.e. PLAN to pay TFA directly for all professional and medical services provided by TFA through the means of electronic funds transfer(s) (EFT) or by check(s) made payable to and mailed to TFA. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. (Initial) _____ I Agree (*)

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. I also give permission for photographs of my feet to be taken that are to be kept as part of my medical record only. They will not be published as part of medical research or disbursed in any way without my permission. (Initial) _____ I Agree (*)

I acknowledge that I was provided a copy of the Notice of privacy policies for Trinity Foot & Ankle and I have read (or had the opportunity to read if I so choose) and understood the Notice as well as the HIPAA regulations for protected medical information.

(Initial) _____ I Agree (*)

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_____ _____

Signature of Responsible Party **Date**

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

Throughout your course of care at Trinity Foot & Ankle, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case during a routine or surgical procedure, that biological specimens such your blood, urine, hair, or bodily fluids may be deposited on medical instruments, bedding, clothing or other objects. These objects may be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Trinity Foot & Ankle to a third party as described above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____

Patient Printed Name

_____

Patient Signature/Parent or Legal Guardian Signature for Minor Patient

_____

Date

Trinity
Foot & Ankle

Financial Policy 2024

Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsible party is responsible for their bill being paid in full. Upon your initial visit you will be asked to provide a photo ID. Please inform us at every visit of any changes to your insurance coverage and provide us with your most recent insurance card.

Please initial each line indicating your understanding of our policies:

____**COPAYMENTS:** It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor.

____**DEDUCTIBLES & CO-INSURANCE:** If you have a high deductible plan, we may collect a **$125** deposit to apply towards your deductible and co-insurance. Any remaining balance after submission to your insurance company is your responsibility.

____**SELF-PAY (for non-covered products and services and for patients without insurance coverage):** Full payment is due at time of service. Payment for evaluation and management services at minimum will be required before seeing the doctor. Additional procedures/services may be recommended by the doctor. You will be informed of these charges before proceeding with treatment.

____**REFERRAL:** If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we will need to reschedule your appointment.

____**NO SHOW(failure to present for your appointment): 24 hours-notice** is required for cancellation of your appointment and failure to do so will incur a **$50** fee. Failure to provide **24 hours-notice** for a scheduled office procedure will incur a **$100** fee.

____**SURGERY CANCELLATION:** Failure to provide **5 business-days'** notice before surgery will incur a **$500** fee.

____**BALANCES/COLLECTION FEES:** If payment of an outstanding balance is not received within 30 days from the postmark date of a mailed statement or e-statement time stamp, a **$10** re-billing fee may be added to each additional statement. Our patient portal offers the ability to view statements and submit payments conveniently and securely. Patients with balances more than 90 days overdue will be turned over to collections and a **$35** administrative fee will be applied.

____**FMLA/DISABILITY/MEDICAL RECORDS:** There is a **$40** charge for having the doctor complete these forms. Requested forms will be completed within 72 hours of diagnosis and care plan. There is a **$30** fee to obtain a copy of your medical records.

I have read and understand these financial policies.
Patient Name (print):

_____

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Patient/Responsible Party Signature:_____
Date: _____/_____/_____

Credit Card on File Agreement

Much like other businesses such as hotels or car rental agencies, upon check-in, a member of our staff will ask you to provide a valid credit card which will be stored securely on file. Following submission of claim and response from your insurance carrier, if a balance is due (from you, the patient or guarantor), a statement will be sent promptly. If no payment has been made after 30 days, your credit card will be charged automatically. Please note that co-payments and any cash products and services provided are due at the time of service.

Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged. If you have any questions about our policy, please do not hesitate to ask.

By signing below, I authorize Trinity Foot & Ankle to keep my signature and credit card information securely on-file in my account. I authorize Trinity Foot & Ankle to charge my credit card for any outstanding balances when due.

If the credit card that I provide today changes, expires, or is declined for any reason, I agree to promptly provide Trinity Foot & Ankle with a new, valid credit card of which I will allow them to use for payment processing over the telephone. Even though Trinity Foot & Ankle is not processing in person, I agree that my updated card may be used with the same authorization as the original card presented.

Visa □ **MasterCard** □ **Discover** □ **American Express** □
Patient's Name (Print):_____ DOB: _____/____/
Name on Card (Print):_____
Last Four Digits of Credit Card Number:_____ Exp. Date:_/
Please fill out information below for any other person(s) you authorize this credit card for:
Patient Full Name (Print):_____ DOB:___/___/_____
Patient Full Name (Print):_____ DOB:___/___/_____
Patient Full Name (Print):_____ DOB:___/___/_____

Credit Card Holder's Signature:_____Date:
_____

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□ Please check this box if you prefer not to receive a statement and would like us to bill your credit card immediately for any balances due after the processing of your insurance.

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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 patient deductibles. These factors are driving offices to either squeeze more patients into shorter periods of time or to stop accepting insurance. 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 on average take between 2-6 weeks to process submitted claims. Whatever the allowed amount is, your copay, coinsurance, and deductible are taken into consideration. Your individual policy determines what you may owe. Once the insurance explanation of benefits (EOB) is received and posted to your account, you will be sent a statement showing your portion. You will have 30 days to send an alternative form of payment if you prefer. If no alternative payment is received, your patient financial responsibility will be processed.

How do you safeguard the credit information you keep on file?
We use the same methods to guard your credit card information as we do for your medical information. The card information is securely protected by the credit card processing component of our HIPAA compliant practice management system. This system stores the card information for future transactions using similar technologies as an online retailer. Our billing and office staff are not able to see the card number – only the last four numbers, giving us no way to use the card outside of the billing system. The only way to use it is to process a payment in our practice management system.

What are the benefits?
It saves you time and eliminates the need to write checks, buy stamps or worry about delays in the mail. It also drives our administrative costs down because our staff sends out fewer statements and spends less time taking credit card information over the phone or entering it from the billing slips sent in the mail, which are less secure methods than storing the information in our practice management system. The extra time the staff has can now be spent on directly helping the patients, either over the phone, with insurance claims, or in person.

I always pay my bills on time. Why do I have to do this?
The entire billing process is time consuming and wasteful, and the few patients that we do have to send to a collection agency end up costing a lot of money. Reducing unnecessary costs are essential to allowing us to continue to be an in-network provider with most insurance companies.

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. This policy in no way compromises your ability to dispute a charge or question your insurance company's explanation of benefits.

Will I still receive a paper statement by mail (or electronically if I prefer)?
Yes. You will receive one statement displaying the amount to be charged to your card in 30 days. If you prefer to pay by an alternative method, you may do so during that period. If you do not wish to make any payment method changes, keep the statement for your records and your card will be automatically charged.

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HIPAA Compliance Patient 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 (HealthInsurance 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: _____

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_____**SELF-PAY (for non-covered products and services and for patients without insurance coverage):** Full payment is due at time of service. Payment for evaluation and management services at minimum will be required before seeing the doctor. Additional procedures/services may be recommended by the doctor. You will be informed of these charges before proceeding with treatment.

___**REFERRAL:** If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we will need to reschedule your appointment or you are seen without a referral, you be held responsible for any charges that your insurance denies.

____**NO SHOW(failure to present for your appointment): 24 hours-notice** is required for cancellation of your appointment and failure to do so will incur a **$50** fee. Failure to provide **24 hours-notice** for a scheduled office procedure will incur a **$100** fee.

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____**OUT OF NETWORK:** In cases when we are not providers for your insurance, your visit will be an Out-of-network service which you will be personally responsible for. Your insurance may impose a deductible and higher copayments than if you received services from a provider in your network. If you do not have Out-of-network benefits, you are personally responsible for the full amount of the charges payable on demand. You are personally responsible for all deductibles and copayments required under your benefit plan and any unpaid charges denied in whole or in part by your insurance.

____**FMLA/DISABILITY/MEDICAL RECORDS:**

There is a **$40** charge for having the doctor complete these forms. Requested forms will be completed within 72 hours of diagnosis and care plan. There is a **$30** fee to obtain a copy of your medical records.

I have read and understand these financial policies. Patient

Name (print):_____

Patient/Responsible Party Signature:_____

Date: _____/_____/_____

Social Media Consent/Release Form

For News Media, Promotional Materials, Written Articles, Research and/or Photographs

I hereby authorize Trinity Foot and Ankle to use my photo and/or information related to my experiences with Dr. Evan Young. I understand this information may be used in publications, including electronic publications, audiovisual presentations, promotional literature, advertising, community presentations, letters to area legislators and media and/or other similar ways. Trinity Foot and Ankle will disclose to me or my legal representative, if necessary and where appropriate, the specific information and/or photo to be used prior to release in the social media.

My consent is freely given as a public service to Trinity Foot and Ankle, without expecting payment. I release Trinity Foot and Ankle and their respective employees, officers and agents from any and all liability which may arise from the use of such news media stories, promotional materials, written articles, videotape and/or photographs.

I understand that my name and likeness will not be used in any way without separate written consent.

I understand that I can revoke this release any time in writing and that the use of any of my photos or other information authorized by this release will immediately cease.

Please print or type:

Name: _____

Signature: _____ Date: _____

The signature of a parent or legal guardian is required if the above individual is under the age of 18 or is not competent.