Foot & Ankle Clinic

www.rochesterfootclinic.com

DATE

PATIENT INFORMATION

PATIENT			DATE OF BIRTH
ADDRESS			☐ MALE ☐ FEMALE
CITY	STATE	ZIP	PHONE
EMAIL			CELL
EMERGENCY CONTACT			PHONE

ALL INSURANCE CARDS WILL BE SCANNED INTO OUR SYSTEM DURING YOUR APPOINTMENT

INSURANCE

Please provide current and accurate information below if you would like us to process your claims for you. Any patient with invalid insurance will be sent a statement for all charges incurred.

PRIMARY INSURANCE COMPANY NAME			COPAY $ _____
POLICY HOLDER'S NAME			DATE OF BIRTH
ADDRESS			PHONE
CITY	STATE	ZIP	☐ SPOUSE ☐ PARENT ☐ SELF

SECONDARY INSURANCE COMPANY NAME			COPAY $ _____
POLICY HOLDER'S NAME			DATE OF BIRTH
ADDRESS			PHONE
CITY	STATE	ZIP	☐ SPOUSE ☐ PARENT ☐ SELF

CURRENT LIST OF MEDICATIONS	DOSAGE

REFERRED BY: _____

ARE YOU DIABETIC? ☐ YES ☐ NO

YES. *Complete required information below for insurance coverage.*

PRIMARY CARE DOCTOR ☐ OMC ☐ MAYO

NAME _____

DATE OF LAST APPOINTMENT _____

LIST OF ALLERGIES

REASON FOR APPOINTMENT

LAST 4 digits of Social Security number for XRAYS				

ACCOUNT #

For office Use Only

LANGUAGE ☐ English ☐ Spanish ☐ Other _____

RACE ☐ White ☐ African American ☐ Other _____

PAST SURGERIES	DATE

SMOKING STATUS ☐ Current ☐ Former ☐ Never	
RECREATIONAL DRUG USE ☐ YES ☐ NO	
ALCOHOL USE ☐ YES ☐ NO How often:	
PREGNANT ☐ YES ☐ NO	**NURSING** ☐ YES ☐ NO
USE OF ☐ Wheel Chair ☐ Walker ☐ Cane	

PAST MEDICAL HISTORY	Have you been treated for any of the following?									
☐	Diabetes	☐	Asthma	☐	HIV	☐	Neuro Muscular Disease	☐	Hepatitis
☐	Gout	☐	Tuberculosois	☐	Epilepsy	☐	Lung Disease	☐	Anemia
☐	Heart Disease	☐	Stroke	☐	Developmental Disorder	☐	Thyroid Disease	☐	
☐	Heart Attack	☐	Cancer	☐	Mental Disease	☐	Bleeding / Blood Clots	☐	
☐	Arthritis	☐	Kidney Disease	☐	Emphysema	☐	High Blood Pressure	☐	

REVIEW OF SYSTEMS	Are you currently experienceing any of the following?							
☐	**GI**	☐	**MS**	☐	**CV**	☐	**EY**	
☐	Heartburn	☐	Weight Change	☐	Chest Pain	☐	Eye Irritation	
☐	Difficulty Swallowing	☐	Joint Disease	☐	Prolonged Bleeding	☐	Eye Injury	
☐	Vomitting	☐	Muscle Pain	☐	Rapid Heartbeat	☐	Impaired Vision	
☐	Stomach Trouble	☐	Joint Pain	☐	Pain Over Heart	☐	Eye Disease	
☐	Stomach Ulcers	☐	Stiffness	☐	High Cholesterol	☐		
☐	Excessive Thirst	☐	Sciatica	☐	Varicose Veins	☐	**ENT**	
☐	Abdominal Pain	☐	Club Foot	☐	Swelling	☐	Hearing Loss	
☐	Change in Stool	☐	Fractures	☐	Leg Pain and Cramps	☐	Sore Mouth	
☐	Liver Trouble	☐	Sprains	☐	Heart Problems	☐	Speech Difficulty	
☐	Difficulty Chewing	☐		☐		☐	Sore Throat	
☐	Nausea	☐	**DM**	☐	**GU**	☐	Dental Problems	
☐	Diarrhea	☐	Itching	☐	Bladder Trouble	☐	Ear Discharge	
☐	Irritible Bowel	☐	Skin Rash	☐	Kidney Stones	☐	Ear Pain	
☐	Constipation	☐	Moles	☐	Prostate Trouble	☐	Nose Bleeding	
☐		☐	Eczema	☐	Change in Urine	☐		
☐	**NR**	☐	Psoriasis	☐	Excessive Urination	☐	**RP**	
☐	Numbness	☐	Discolorations	☐	Difficult Urination	☐	Persistent Cough	
☐	Dizziness	☐	Hives	☐	Frequent Urination	☐	Lung Problems	
☐	Muscle Jerking	☐	Bruises	☐	Painful Urination	☐	Coughing Phlem	
☐	Convulsions	☐	Ulcerations	☐		☐	Wheezing	
☐	Headaches	☐		☐		☐	Difficult Breathing	
						☐	Coughing Blood	
						☐	Bronchitis	

☐ **VA PATIENT** **SS#** _____ **AUTH#** _____

WORKMAN' COMP INSURANCE: _____

ADDRESS TO SEND CLAIMS TO: _____

CLAIM #: _____ DATE OF INJURY: _____

CONTACT PERSON: _____ PHONE: _____

Foot & Ankle Clinic
www.rochesterfootclinic.com

2768 Superior Drive NW suite B • Rochester MN 55901
p: 507.282.1053 f: 507.282.1384

PRIVACY POLICY

The Department of Health and human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standerd of certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information and information about treatment, payment or health care operation, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. under this law, we have the right to refuse to treat you should you choose to disclose your Personal Health Information (PHI). If you chose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review our policy notice, to request restrictions and revoke consent inwriting after you have reviewed our policy notice.

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that our staff continually undergos training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule" We strive to acheive the highest standards of ethics and inegrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. we want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use PHI

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. If you have any objections to this form, please ask to speak with our HIPPA Compliance Manager.

Patient Signature or Authorized Representative _____ **Date of Signature** _____

Printed Name of Authorized Representative _____ **Relationship to Patient** _____
Documentation of legal authority required

Foot & Ankle Clinic
Dr. Stephen Panetta

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Rochester MN 55901
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2022 FINANCIAL POLICY

The filing of insurance claim forms is a courtesy that we extend to our patients.

YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. **OUR RELATIONSHIP IS WITH YOU, NOT YOUR INSURANCE COMPANY.**

- INSURANCE POLICIES ARE RAPIDLY CHANGING along with ID numbers and Group numbers each year. Many patients will have made changes to their insurance policies or insurance carriers for 2022. We rely on you to inform us of all insurance policies that are valid for 2022. All claims need to be sent to a **valid** insurance carrier. If you do not inform us of changes within 7 days of the date of service, you will be financially responsible for the services rendered. All patients with Diabetes are required by insurance to provide the name of their primary doctor and the date they last saw them. Date needs to be within 6 months prior to scheduled appointment at F&AC.
- IN 2022, ALL PATIENTS will need to have all current insurance cards with them for EVERY VISIT at our clinic, to reduce the number of invalid policies when we submit your claims. ANY insurance changes or updates must be given to the front desk when you check in for your scheduled appointment. You will be asked to provide the policy holder's: full name, date of birth, address and relationship to the patient for each insurance carrier. Any office visit copayments listed on your insurance card will be collected at the front desk when you check in for your appointment. Our physicians are specialists if your card indicates a different copay amount. We accept cash, check, debit, Visa, Mastercard, or Discover Card for Payment.
- ALL INSURANCE CARDS will be scanned into our billing system. If the insurance card does not check out as valid in our system, you will not be allowed to see your provider. We will reschedule your appointment for when you can provide accurate and valid insurance. Any patient may choose to pay cash upfront for their services if they do not want to reschedule their appointment. You will be reimbursed once you provide us with valid insurance cards and your claims have been processed. A $125.00 deposit is required for all patients without any medical insurance coverage on the first date of service at our office. This will be applied to your account and a statement will be sent reflecting any additional monies owed.
- IT IS YOUR RESPONSIBILITY to know the specifics of all your insurance policies. It is important that you know if our clinic and our physicians are in your insurance network or not for your coverage. You need to understand if there are any referral requirements for you to be seen at our clinic. Often, this is not indicated on your insurance card, so our staff is unable to give you the correct answer. Many policies have co-payments, co-insurance and deductibles that are the patient's responsibility to pay. If you have ANY questions about your policy, PLEASE call the customer service phone number on the back of your insurance card.
- WHEN MULTIPLE POLICIES EXIST, it is vital that you inform us which policy your claims get sent to first (Primary) and which one your claims get sent to next (Secondary), after the first insurance (Primary) has paid its portion. Contact your insurance carriers if you are not sure. The correct order for processing claims is VERY important.
- IF YOUR CLAIMS ARE DENIED by your insurance, all charges are your responsibility for the date of service rendered. You are also responsible for any services or products that your insurance carrier states is a noncovered service such as supplies, surgical shoe, diabetic shoes and inserts, orthotics, etc. We will send you a statement if any balance is owed following the response from your insurance carrier(s). You will not receive a statement if your insurance has paid in full. CALL 1-855-255-1036 with any questions about your statement.
- WORKMAN'S COMPENSATION claims are paid by your employers workman's comp insurance company. They pay for services and supplies deemed necessary and as pertains to a work injury. A claim number, company, address, and contact person is required to file these claims. If any part of the claim is denied, you are responsible for these charges.
- **We reserve the right to charge a fee for completion of disability forms or other packets of requested documentation.**

PATIENT INSURANCE AUTHORIZATION I herby authorize the processing of my medical insurance either by electronic or manual method. My signature authorizes payment of all major medical and/or surgical benefits, to which I am entitled, to be paid to the above provider. I further authorize the asignee to release all medical and / or insurance claim information necessary to secure payment. I recognize my financial obligation of any co-payment, co-insurance, deductible or noncovered services that may be required. I will notify my provider of ANYchanges to my insurance policies. This agreement will remain in effect until revoked by me in writing. I understand that I am ultimately responsible for all charges on my account. I have read the above Financial Policy and I understand and accept the terms as they are stated above. I have provided current identification cards for my insurance.

Patient Signature or Authorized Representative _____ **Date of Signature** _____

Printed Name of Authorized Representative _____ **Relationship to Patient** _____
Documentation of legal authority required