CAROLINA FOOT AND ANKLE ASSOCIATES

To Whom It May Concern:

In an effort to comply with Medicare requirements and guidelines, Carolina Foot & Ankle Associates created a policy for all new nursing home patients to facilitate the appointment process. Unfortunately, we continue to have problems with patients arriving without authorization to be treated, without adequate medical histories, or without a clear reason for the referral.

Because of this concern, we are now requiring a family member or power of attorney to be with the patient at each visit.

Effective immediately, all patients from a facility will require the following:

1. For new patients, paperwork must be completed in full and returned to CFAA for our staff to review **prior to scheduling**. We are happy to send and receive the paperwork via fax for your convenience. If the patient is not responsible for his or her bills, the power of attorney must sign on the patient's behalf. Please provide the following information:

   a. Complete list of current medications & allergies

   b. Complete medical problem list (if the patient does have severe PVD, it must be noted to ensure coverage for palliative services)

   c. Copy of all insurance cards

   d. A written order stating the reason for the patient's appointment

2. Any established patients receiving routine foot care must pay the $56 visit fee at the time of service. If the patient is not responsible for their bills and there is no power of attorney, please note that we will hold the facility responsible for any unpaid routine care charges.

3. Medicare patients who do not have secondary coverage must pay their coinsurance at the time of service.

If you have any questions regarding the above policy, please feel free to contact me directly. Thank you in advance for your cooperation

Sincerely,

Teresa McDonald

Practice Administrator

CAROLINA FOOT & ANKLE ASSOCIATES, PLLC

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____ Appointment Date: _____

Shoe Size_____

Social History

Do you smoke cigarettes? ___ No ___Yes If so, for how many years? ____ How many packs per day? _____

Are you a former smoker? ___ No ___Yes If so, for how many years? ____ How many packs per day _____

Do you drink alcoholic beverages? ___ No ___ Yes What kind & approximately how many each week? _____

Are you employed? ___ Yes ___ No ___ Retired Are you pregnant? ___ Yes ___ No

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Signature: _X_____ Date: _____

Patient or Personal Representative

To be used by Carolina Foot & Ankle Staff:

BP (sitting): _____/_____ Pulse _____/min (Reg. Irreg.) Resp. _____/min Temp: _____°F Height _____

Weight_____ If over 65, Falls?_____

CAROLINA FOOT & ANKLE ASSOCIATES, PLLC

DEMOGRAPHICS

Patient's Last Name: _____First: _____ Middle Int: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Gender: _____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Preferred language: _____

Social Security: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Primary Care Doctor's Practice Name:_____

Email Address: _____ Primary

Insurance: _____Secondary Insurance: _____

Who carries the insurance? ☐ The patient ☐ Other (Name): _____ DOB: _____

How did you hear about our practice? _____

Is the patient in a facility (ex: nursing home)? Name: _____ Phone: _____

Responsible Party
If someone (other than the patient) is responsible for the patient's bill, please complete the following:

Responsible Party's Name: _____Relationship to patient: _____

Mailing Address: _____City: _____ State: _____ Zip: _____

Emergency Contact: _____**Relationship to Patient**_____

Home: _____ Cell: _____ Work: _____

I authorize the release of any medical information necessary to process my Insurance Claim and request payment of benefits to the doctor. I hereby give permission to the doctor to administer treatment and to perform any minor procedures as may be needed in the diagnosis and/or treatment of my foot and ankle condition. I understand that services rendered should be paid for at the time of service unless other arrangements have been made.

I authorize payment of insurance benefits to the doctor. This authorization applies to all dates of service until revoked.

Signature: _X_____ **Date:** _____
Patient or Personal Representative

CAROLINA FOOT & ANKLE ASSOCIATES, PLLC

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY/FRIENDS

Patient Name: _____ **Date of Birth:** _____

Carolina Foot and Ankle is authorized to release protected health information about the above-named patient to the entities named below:

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
☐ Are we able to leave a voice mail for you? Please indicate the type of information we are able to leave in the voice mail in the section to the right.	□ Results of lab tests/x-rays □ Appointment reminders □ Other_____
☐ Other person (s) we may speak to about you. (Provide name and phone number) What type of information may we discuss? 1._____ 2._____ 3._____	□ Financial □ Medical □ Able to pick up supplies □ Permission to bring minor/dependent and to consent for treatment
☐ Email Communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	□ Financial □ Medical □ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	□ Appointment reminder □ Other:

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

□ Photo of patient received by patient or legal guardian □ Photo taken by staff (Example: pre/post procedure) □ Other	□ May be posted in office □ May be posted on website □ Other_____

Please note that we we participate in NC HealthConnex (North Carolina's state-operated Health Information Exchange). More information about the exchange, including details about how to opt out can be found at hiea.nc.gov/patients

Notice of Privacy Practices: Our notice of privacy practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices. By signing below, you are agreeing that you have had the opportunity to read our notice of privacy practices.

Signature: X_____ **Date:** _____
Patient or Personal Representative

CAROLINA FOOT & ANKLE ASSOCIATES, PLLC
FINANCIAL POLICY

Patient Name: _____ **Date of Birth:** _____

YOUR INSURANCE
Our relationship is with you, not your insurance company. If we are a participating provider with your insurance, we will file your claim for you. We do not; however, file third party payer claims for motor vehicle, worker's compensation, or other accidents. If you do not have your insurance card at the time of service, it may be necessary for you to pay for your visit in full.
According to our insurance contracts, we are obligated to collect the patient's responsibility at the time we provide services. Therefore, any applicable co-pays, coinsurance, or deductible amounts must be paid at each visit. In the case of high deductible plans (including HRAs and HSAs), the contracted amount will be due from the patient at the time of service. If you require a procedure, a member of our staff will contact your insurance company to confirm eligibility and gain an estimate of your benefits. Prior to the procedure, you are required to pay in full for your estimated out-of-pocket expense related to the procedure. Patients with a history of not paying these fees may be discharged from our practice and their insurance carrier will be notified. Payment must be made in full for any services considered by your insurance as "non-covered" or "not reasonable or necessary".

Some insurance companies may require a pre-certification or pre-authorization for certain services. While we will gladly assist you with this process, the final responsibility to insure that any such requirements are completed prior to treatment is yours. Denied charges due to lack of proper pre-certification/pre-authorization will be billed to you.

IF YOU DO NOT HAVE INSURANCE
A minimum deposit of $250 is due at check in for all self-pay patients. Charges for follow up visits will be due at the time of service.

NO SHOWS
Please try to give our office 24 hours advance notice of cancellation so we may offer the appointment to another patient. Repeatedly missing appointments without adequate notice may lead to dismissal from the practice.

RETURNED CHECKS
There is a $25 service fee for all checks returned for non-sufficient funds. A third party service will attempt to have the check clear your account twice before returning it to us as uncollectable. Patients who have written returned checks will be required to pay for subsequent visits using cash or a credit card.

COLLECTIONS
If you are unable to pay your account in full as billed, please contact our office to make other financial arrangements. Overdue accounts with inactivity after 90 days may be assigned to a collection agency for follow up. Regrettably, patients referred to collections will be dismissed from our practice.

PATIENT REFUNDS
After all insurance balances have been settled, we will issue patient refund checks for credit amounts over $10. Checks are written once per month. Due to administrative costs, credit balances under $10 will be held on account for a return appointment.

MEDICAL RECORDS
In order that we may keep your information up to date, please inform us of any changes, including insurance, address, or phone number.

We are happy to complete disability, FMLA etc. forms for our patients. Before leaving the form with us, please make sure you have filled in the patient portion. There will be a $15 fee for your first form and a $5 fee for any related follow up form. Please allow five business days for processing. A signed release form is required before we are able to send completed forms.

Upon your request, copies of x-rays and medical records may be made available for your pick up by giving us a 48 hour notice. As a courtesy, the first two x-ray films are free. Each film thereafter is $10. X-ray discs are $5 each. There will be a minimum charge of

$10 for medical record copying; however, with your written authorization we are happy to fax your medical records directly to another physician at no charge.

By signing below I acknowledge that I have read the above financial information and agree to adhere to the policies outlined.

Signature: _X_____ **Date:** _____

Patient or Personal Representative