PATIENT INFORMATION

Patient's Name: _____
First M.I. Last

Home Ph.: _____ Cell Ph.:_____ Work Ph: _____

Address: _____City: _____ Zip: _____

Date of Birth: _____ ❑ Male ❑ Female

Social Security #: _____ Driver's License/I.D. #: _____

Employer: _____ Phone: _____ Occupation; _____

Employer Address: _____ City: _____ Zip: _____

Subscriber's Name: _____ Date of Birth: _____ Social Security #:_____

Subscriber's Employer: _____ Phone: _____

Name of Insurance Plan: _____ Policy or I.D. Number: _____

Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widowed

Spouse's Name: _____ Employer: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____ Relationship:_____

Responsible Party if a Minor: _____ Phone: _____

Email address: _____

Primary Care Doctor: _____

Address: _____

Name & Address of your Pharmacy _____

Where do you go for lab work _____

Where do you go for Radiology (x-rays/MRI's) _____

How did you hear about us? ❑ Walk-In ❑ Yellow Pages ❑ Website ❑ Sign ❑ Previous Patient
❑ Dr Referral _____ ❑ Patient Referral _____ ❑ Employee Referral_____ ❑ Other

Please present your current insurance card and I.D. so we may copy them for verification of coverage

Chart #: _____

HEALTH QUESTIONNAIRE

NAME: _____ AGE: ____ HT: _____ WT: _____ DATE: _____

Allergies to Medications:

_____

_____

_____

List all medications you now take:

_____

_____

_____

All other allergies:

_____

_____

List all medications you have taken in the past year:

_____

_____

List all major medical illnesses you have had in the last 5 years:

_____

_____

_____

Current Shoe Size: _____

List all operations you have had in the last 5 years:

Type of anesthesia:

Date of operation:

_____ _____ _____

_____ _____ _____

_____ _____ _____

EXPLAIN YOUR CHIEF COMPLAINT?

_____

_____

_____

	LEFT	RIGHT
LEG	❑	❑
ANKLE	❑	❑
FOOT	❑	❑

Is this foot problem a result of a **work injury** or **accident**? ❑ No ❑ Yes, please explain:

_____

_____

Date of injury or accident (if applicable): _____ Claim: _____

Adjustor Name: _____ Phone: _____

Are you under the care of any physician now? ❑ Yes ❑ No

Physician's Name: _____ Phone: _____

MEDICAL HISTORY

Do you or have you ever had:	*YES*	*NO*	*COMMENTS:*
• Anemia?	❑	❑	
• Anesthesia Reaction?	❑	❑	
• Arthritis?	❑	❑	
• Asthma?	❑	❑	
• Bleeding Disorder?	❑	❑	
• Do you take aspirin or on a blood thinner	❑	❑	
• Cancer?	❑	❑	
• Circulation Problems?	❑	❑	
• Diabetes?	❑	❑	
• A1c level _____ or blood glucose _____ Treating physician & date of last visit			
• Gout?	❑	❑	
• Heart Disease?	❑	❑	
• Heart Attack?	❑	❑	
• Stroke?	❑	❑	
• Hepatitis?	❑	❑	
• High Blood Pressure?	❑	❑	
• HIV/AIDS?	❑	❑	
• Kidney Disease?	❑	❑	
• Liver Disease?	❑	❑	
• Nerve Disorders?	❑	❑	
• Phlebitis/Blood Clots?	❑	❑	
• Pulmonary/Lung Disease?	❑	❑	
• Skin Problems/Rashes?	❑	❑	
• Prolonged Healing? Prone to infections?	❑	❑	
• Stomach/Intestinal Problems?	❑	❑	
• Do you/have you ever smoked?	❑	❑	
• How long ago? Packs per day?	❑	❑	
• Drink alcohol? How much/How often?	❑	❑	
• Breathing Problems/Short of breath?	❑	❑	
• Do you have chest pain?	❑	❑	
• Cramping or pain at night?	❑	❑	
• Cramping or pain after walking?	❑	❑	
• Are your feet especially cold?	❑	❑	
• Low back pain?	❑	❑	
• Pain in feet or legs?	❑	❑	
• Joint pain or swelling?	❑	❑	
• General muscle aches?	❑	❑	
• Swelling in the feet or legs?	❑	❑	
• Problems keeping your balance?	❑	❑	
• Tingling, burning, or numbness in feet?	❑	❑	
• Epilepsy, seizures or fainting	❑	❑	

Patient Signature: _____ **Date:** _____

PATIENT FINANCIAL POLICY

Thank you for choosing **The Foot and Ankle Institute of NV, LLC** as your healthcare provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, phone, insurance information, etc.)

Co-pays, Co-insurance and Deductibles
The patient is expected to present an insurance card at each visit. All co-payments, co-insurance, applicable deductibles and past due balances are due at time of check-in unless previous arrangements have been made with a billing representative. We accept cash, check, debit cards or credit cards (Visa, Mastercard or Discover card only and we take Care Credit.)

Insurance Claims
Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your insurance company (ies) but in order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Referrals and Preauthorizations
If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. We do our best to obtain this for you as a courtesy to you, but it is ultimately your responsibility.

Self-pay / Uninsured Accounts
Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which we not contracted or patients without an insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to bring $125.00 at the initial appointment. Extended payment arrangements (up to 6 months only) are available if needed. Please ask to speak with a billing representative to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Minors
The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy
It is our office policy that all past due accounts be sent three statements. If payment is not made on this account, two letters will be sent to try to collect balance in full or to make payment arrangements. If no resolution can be made, the account may be sent to the collection agency and possible discharge from the practice. The financially responsible person will be responsible for all collection costs, fees etc.

FINANCIAL CONSENTS

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES

I hereby authorize Ford Center for Foot Surgery and Foot & Ankle Institute of NV, LLC to release any information in the course of my examination and/or treatment to my insurance company (ies) for the purpose of billing. I also authorize the release of information to my employer if my examination and/or treatment is/are work related.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize the medical and/or surgical benefit payments to be made directly to Ford Center for Foot Surgery and Foot & Ankle Institute of NV, LLC. It is understood that benefits are not to exceed the reasonable and customary charge for these services and any monies received from the insurance company over and above any indebtedness will be refunded to me when my bill is paid in full. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE COMPANY (IES) AND THIS AUTHORIZATION.

PATIENT ACKNOWLEDGEMENT OF PHYSICIAN DISCLOSURE OF OWNERSHIP INTEREST

This is to advise you that doctors have ownership interests in this surgery center. This is to further advise you that you may choose any facility available for the purpose of obtaining the particular procedure or test being performed and to let the physician know if you wish to choose a certain facility or center other than this one.

Please let us know if you have any questions or concerns.

I HAVE READ AND UNDERSTAND THIS POLICY AND THE ABOVE PARAGRAPHS.

PATIENT'S OR GUARDIAN'S SIGNATURE **DATE**

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Ford Center for Foot Surgery
Foot & Ankle Institute of NV, LLC
2321 Pyramid Way
Sparks, NV. 89431
Phone: (775) 331-1919
Fax: (775) 331-2008

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of the Ford Center for Foot Surgery and Foot & Ankle Inst. of NV, LLC, *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that the surgery center has a right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations and that I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

If we need to contact you regarding your treatment or finances, who else may we discuss or leave a message with? May we leave a message on your phone of record, re: treatment ❑ billing ❑

Name: _____ Relationship: _____ Treatment ❑ Billing ❑

Name: _____ Relationship: _____ Treatment ❑ Billing ❑

Patient Name: _____ **Date**: _____

Signature: _____ **Date**: _____

If patient is a minor, relationship to minor: _____

ERISA ASSIGNMENT OF BENEFITS

I assign the right to payment for all medical benefits directly to Douglas R. Doxey, DPM, in consideration for medical services and supplies provided pursuant to my health insurance plan.

In the event my health insurance plan refuses to pay for provided, medically necessary services, I also assign all my *ERISA rights to Douglas R. Doxey, DPM for a fair and full review of any and all denied claims. This ERISA assignment is in consideration for the unpaid services provided and in consideration for the continued willingness of Douglas R. Doxey, DPM to see patients, including myself, on an insurance assignment basis. I understand that if my treating doctor prevails in any such payment dispute, I may be liable for co-payment for the contested services.

I give consent to release medical information to Douglas R. Doxey, DPM. I give consent to Douglas R. Doxey, DPM to release medical information to other healthcare providers for the purpose of treatment, when necessary to my care. I give my consent to Douglas R. Doxey, DPM to send medical information, as necessary, to my insurance plan.

Note: Under no circumstance will I cash any checks made payable to me from my Insurance Company for services rendered by Ford Center for Foot Surgery and Foot & Ankle Inst. of NV, LLC.

**ERISA is an acronym for the Employee Retirement Income Security Act. The Employee Retirement Income Security Act includes federal laws requiring insurance companies to process submitted claims and appealed (denied) insurance claims according to ERISA regulations. The failure to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations may result in fines charged to the insurance company in amounts up to $100 per day for each infraction.*

Patient's printed name: _____

Patient's signature: _____

Date: _____

FOOT & ANKLE INST. OF NEVADA, LLC

DR. DOUGLAS DOXEY, DPM, ABPS

DISCLAIMER

IN REGARDS TO THE USE OF ANY OUTSIDE LABORATORY TESTS, OUTPATIENT TESTS, RADIOLOGY TESTING. FOR EXAMPLE: BLOOD WORK, CULTURES, MRI'S, AND PATHOLOGY TESTING IN SURGERY ETC.

With all the changes in healthcare today, it is very difficult to keep abreast of which facilities are "Preferred Providers" for each insurance carrier. Every effort is given to scheduling and sending procedures and specimens to a contracted facility for your insurance.

However, ultimately the responsibility for guaranteeing that you are being scheduled or sent to the correct facility/lab falls on **YOU THE PATIENT.** Incorrect facilities can lead to reductions in your benefits and increased cost to you the patient. Routine labs may not be covered by your insurance. It is your responsibility to verify your coverage.

If you find that you are scheduled at a non-participating facility, or your specimen is being sent to a non participating/out of network lab, contact this office immediately. This must be done before your service date or specimen pickup.

The Doctors and the staff will not be held responsible for any disallowed charges due by you the patient.

My required lab is: Lab Corp___ Quest___ Renown___ Other_____

My required radiology is: RDC___ Renown___ Other_____

I HAVE READ THE ABOVE DISCLAIMER AND FULLY UNDERSTAND MY RESPONSIBILITIES.

Patient signature: _____

Date: _____

FOOT & ANKLE INST. OF NV, LLC

Cancellation Policy/No Show/Late Policy
As of July 13, 2016

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you may be charged a $25.00 cancellation fee. The cancellation and no show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with the management approval.

We understand that delays can happen however we must try to keep the other patients and doctor on time. If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Dept. 775/331-1919.

Please sign that you have read, understand and agree to this Cancellation and No Show/Late Policy

_____ ___/___/___

Patient Name (Please print) Date

_____

Signature of Patient/Guardian

PRESCRIBING CONTROLLED SUBSTANCES IN NEVADA
AS OF JANUARY 1, 2018
AB 474

Before writing an initial prescription a practitioner will perform a PATIENT RISK ASSESSMENT. After the assessment the script will be for no more than a 14 day supply and the patient must complete an INFORMED CONSENT.

INFORMED CONSENT
The practitioner must obtain informed written consent after discussing the following with the patient:

- The potential risks and benefits of using the CS, including the risks of dependency, addiction and overdose
- The proper use, storage and disposal of the CS
- Possible alternative treatment options
- The patient's treatment plan
- How the practitioner will address requests for refills
- Risk of CS exposure to a fetus of a childbearing age woman
- If the CS is an opioid, the availability of an opioid antagonist without a prescription
- If the patient is an unemancipated minor, the risks that the minor will abuse, misuse, or divert the CS, including ways to detect those issues

Prescribing after 30 days:
A practitioner who prescribes a CS to treat pain for more than 30 days must, not later than 30 days after issuing the initial prescription, enter into a *Prescription Medication Agreement* with the patient. The agreement must be part of the patient's record, and the practitioner must update it at least every 365 days while the patient is using the CS or whenever the practitioner changes the treatment plan. The agreement must include:

- Goals of the treatment
- Patient's consent to drug testing when deemed necessary by the practitioner
- A requirement that the patient take the CS as prescribed
- A prohibition on sharing the medication with any other person
- A requirement that the patient inform the practitioner of
    - Any other CSs prescribed or taken by the patient
    - Whether the patient drinks alcohol, uses cannabinoid or illicit drugs
    - Whether the patient has been treated for side effects or complications relating to the use of the CS

- Each state in which the patient previously resided or had a prescription for CS filled

- Reasons the practitioner may change or discontinue the treatment

Prescribing after 90 days:
A practitioner who prescribes a CS to treat pain for more than 90 consecutive days must:

- Determine an evidence-based diagnosis for the cause of the pain
- Complete a *Risk of Abuse Assessment* validated through peer-reviewed research
- Discuss the treatment plan with the patient
- Obtain and review the patient's PMP Report at least every 90 days during the course of treatment
- If the patient is receiving a dose that exceeds 90 MME daily;
  - Consider referring patient to a pain management specialist
  - Develop and document in the patient's medical record a revised treatment plan including an assessment of increased risk for adverse outcomes

Prescribing after 365 days:
A practitioner should not prescribe a CS to a patient who has already received 365 days' worth of that CS for a particular diagnosis in any given 365 day rolling period. Similarly, a practitioner should not prescribe more doses of a CS than the patient needs if he or she adheres to the practitioner's dosing instructions for the treatment period. In either scenario, the practitioner may choose to prescribe a larger quantity than the patient needs for the treatment period, so long as the practitioner documents his or her rational in the patient's medical record.

Name (print): _____ Date: _____

Signature of patient or guardian: _____