Foot and Ankle Doctors, PC
Robert Colligan, DPM

Patient Name_____ **Age**____ **DOB**_____ **Marital Status** _____

Family Physician_____ **Who referred you here**_____

Describe your foot/ankle problem and cause if known_____

Previous treatment by yourself or professional_____

List Current and Past
Surgeries_____

_____

_____

Hospitalizations_____

_____

Medication Allergies_____

Latex allergy? Yes_____ No_____ **Currently pregnant?** Yes_____ No_____

Please check yes or no if YOU have had any of the following-Please explain

Yes	No	Problem	Yes	No	Problem
__	__	Chest pain_____	__	__	Fibromyalgia_____
__	__	Heart Problems_____	__	__	Cramps/location_____
__	__	Mitral Valve prolapse_____	__	__	Numbness/location_____
__	__	High blood pressure_____	__	__	Thyroid_____
__	__	High cholesterol_____	__	__	Diabetes_____
__	__	Circulation_____	__	__	Lung Problems_____
__	__	Bleeding Tendency_____	__	__	Asthma/emphysema_____
__	__	Stroke/TIA_____	__	__	Liver/gallbladder_____
__	__	Swelling/location_____	__	__	Kidney_____
__	__	Seizure disorder_____	__	__	HIV positive_____
__	__	Weight loss/Gain_(circle one)_____	__	__	Skin problems_____
__	__	Stomach _____	__	__	Drink Alcohol_____
__	__	Anemia_____	__	__	Tobacco use_____
__	__	Gout_____	__	__	Illegal drugs_____
__	__	Back pain_____	__	__	Cancer_____
__	__	Arthritis_____	__	__	Other_____
__	__	Malignant Hyperthermia_____			

Please complete back portion.

Health Information

Please indicate who, other than yourself, in your immediate family has/had the following:

Cancer_____ Diabetes_____

Heart condition_____ High Blood Pressure_____

Kidney Disease_____ Mental/emotional_____

Stroke_____ Arthritis_____

Malignant hyperthermia_____

Please list medications including over the counter medications, herbs, vitamins. If you have a list we would be happy to copy that for your records.

Current medications	Dosage	Times taken

Signature_____Date_____

Form verified by_____ Date_____

Foot & Ankle Doctors, PC

Robert Colligan, DPM • 110 N 37th St., Suite 101 • Norfolk, NE 68701

(Phone) 402-371-4690 • (Fax) 402-379-8061

Patient Information

Patient Legal Name _____ ___Single ___Married ___Widowed ___Separated ___Divorced

(First - Middle - Last Jr/Sr/Etc.) Patient's Social Security# _____

Physical Address _____ Student ___Yes ___No If yes, ___Full time ___Part time

Mailing Address _____ Employer _____

City _____ State _____ ZIP _____ Address _____

Date of Birth _____ Age_____ Sex: ___M ___F City _____ State _____ ZIP _____

Home Phone (_____)_____ Cellular Phone (_____)_____ Work Phone (_____)_____

Guarantor/Consenting Party Information (If other than Patient)

Is this party the insurance subscriber? ___Primary Insurance ___ Secondary Insurance

Name _____ Social Security #_____ Date of Birth _____

(First - Middle - Last Jr/Sr/Etc.) Relationship to patient _____ Sex: ___M ___F

Physical Address _____ Employer _____

Mailing Address _____ Address _____

City _____ State _____ ZIP _____ City _____ State _____ ZIP _____

Home Phone (_____)_____ Cellular Phone (_____)_____ Work Phone (_____)_____

Spouse's Information (Of Guarantor/Consenting Party)

Name _____ Employer _____

(First - Middle - Last Jr/Sr/Etc.) Address _____

Social Security #_____ Date of Birth _____ City _____

Home Phone (_____)_____ Cellular Phone (_____)_____ Work Phone (_____)_____

Relationship to Patient _____ Sex: ___M ___F

Insurance/Payment Information

Do you have insurance? ___YES ___NO Insurance Name _____

If you do not have proof of insurance at the time of visit, you will be required to pay in full today.

Policy Holder _____ Relation to Patient _____ Date of Birth _____ Sex: ___M ___F

Social Security #_____ Group #_____Policy #_____ Employer _____

I understand as the Consenting Party, I am responsible for payment of this account.

General Information

Maiden Name/Alias _____ Primary Language_____ Ethnicity_____

Emergency Contact Name _____ Number (_____)_____

The patient registration form must be completed in its entirety & the Release and Assignment Authorization signed by the Responsible/Consenting Party prior to treatment. Foot and Ankle Doctors considers this information a condition of treatment.

- I hereby authorize the Providers of Foot and Ankle Doctors to administer medication, anesthetics & perform such procedures as may be deemed necessary in the diagnosis & treatment of the patient.
- I hereby authorize release of any medical information regarding this visit to my insurance and/or primary care physician & also ASSIGN to the PROVIDER all payments from my insurance.
- I UNDERSTAND that I am financially responsible for all charges whether or not paid by insurance.
- I UNDERSTAND that not all Providers with Foot and Ankle Doctors may be a participating provider with my insurance.
- I UNDERSTAND and AGREE to the above conditions.

_____ Date_____

Signature

This agreement will remain on file for approximately one year & will be considered a condition of all treatment until a new form is completed.

Payment for services is due on the day of the service. As a part of our service, we will submit your claim to insurance.

Account # _____

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we **require** you to read and sign prior to any treatment. This statement is our way of continuing to serve you by providing quality, affordable healthcare by reducing unnecessary costs and insurance delays. The terms of this Financial Policy apply to all departments of Foot and Ankle Doctors. Part of your visit may be billed through an outside laboratory, pathology service, medical imaging consultants, or other radiology center, depending on the type of treatment received. We do not guarantee that outside services will be contracted with your insurance company. This is the patient's responsibility.

All patients **must** complete our Information and Insurance form before seeing the doctor.

YOUR COPAY IS DUE AT THE TIME OF SERVICE

WE ACCEPT CASH, CHECKS, CREDIT or DEBIT CARDS. WE ALSO ACCEPT CARE CREDIT

Regarding payment of your service: All patients with valid insurance coverage are required to pay in full any applicable co-pay, as specified in your Policy Handbook, at the check-in counter. If a co-payment does not apply, you will be required to pay 20% of your services, regardless of your deductible or coinsurance percentage. Patients without insurance are required to pay in full, your portion of your visit and you will be asked to provide proof of ability to pay at the check-in counter. The balance is your responsibility whether your insurance company pays or not. In the event that your insurance does not pay in full for your visit and a bill is required a Finance Charge of 1.25% will be assessed monthly to all balances not paid in full within 30 days of the statement date. I understand I am responsible for any and all charges regarding my visits whether or not paid by my insurance.

Regarding Insurance Plans: Valid insurance information must be obtained prior to treatment, or payment in full is due. If you have applied for Nebraska Medicaid, but have not yet been accepted, payment in full is required. Your insurance policy is a contract between you and your insurance carrier and we are not a part to that contract. It is up to you to determine whether the physician is contracted with your insurance company each time you are seen. It is advised for you to contact your insurance prior to treatment to verify the PPO status of the physician as indicated in your Policy Handbook. In the event that your insurance coverage changes to a plan where we are not a participating provider, your insurance may require you to pay our office according to your out-of-network benefits. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical services. I hereby authorize release of all medical information regarding my visits to my insurance company and/or my primary care physician and assign the provider all payments from my insurance.

Regarding work related injuries: We will file any Worker's Compensation claims with your employer to be filed with your Worker's Compensation Carrier. We do require a copy of applicable health insurance coverage information to file a claim with this coverage in the event the Worker's Compensation Carrier denies your claim. Written or telephone authorization is **required** from your employer prior to treatment. In the event authorization is not obtained, any applicable health insurance carrier will be billed or payment in full is due at the time of service. If you receive authorization from your employer following treatment, we must be notified immediately at 402-371-4690. We do not bill automobile accident claims, personal property claims, etc. You will be billed for the treatment rendered and can submit to the appropriate entity.

Usual and customary rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Regarding minor patients: Minor patients must be accompanied by an adult or be able to provide a signed consent for medical treatment prior to being seen. The adult accompanying a minor and the parent(s)/guardian(s) are responsible for full payment. Unaccompanied minors receiving non-emergent treatment will be denied unless charges have been pre-authorized for payment by a credit/debit card, cash, or check at the time of service.

Collections: We reserve the right to forward any account to a third party collection agency/attorney at any time we determine the account to be un-collectible/delinquent. Our collection agency reports bad debts. Patients/Guarantors with a prior collections history with Foot and Ankle Doctors may be asked to pay in full at the time of the appointment or make a standard deposit if the appointment charges are not yet determined. Foot and Ankle Doctors participates with Check Mate. Fees will apply on returned checks.

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I have read the Financial Policy. I understand and agree with the terms.

X_____ _____ Date: _____

Signature of Patient or Responsible Party Relationship of Responsible Party

X_____ Date: _____

Witness – Foot and Ankle Doctors staff

Patient Name: _____DOB: _____Acct#: _____

Robert Colligan, DPM • 110 N 37th Street, Suite 110 • Norfolk, NE 68701

Authorization for Release of Information

I hereby authorize Foot and Ankle Doctors, PC to release information from my medical record as indicated below. I understand the information may be released per phone or per written medical records. This will include but not limited to: medical and or billing information. If no one is listed on this form, information will be released ONLY to the patient. This will include medical and billing inquires, and the scheduling of appointments. If the patient is a minor, information will be released to the parent/guardian that signed the initial form. This information will remain on file and as written, unless otherwise changed by the patient and/or Foot and Ankle Doctors, PC. I understand I can amend this information at any time.

Name _____ Relationship_____

Address _____ City _____ State _____ Zip _____

Phone _____

Name _____ Relationship_____

Address _____ City _____ State _____ Zip _____

Phone _____

Name _____ Relationship_____

Address _____ City _____ State _____ Zip _____

Phone _____

Authorization to produce or use images

I hereby agree that Foot and Ankle Doctors, PC has the right to photograph or video tape (using film and electronic devices), use and reproduce my images. I am aware my images will be stored in my medical record with my personal information attached. This information may be supplied to a referring physician as necessary for continuation of care. I am aware my images may be used for educational, research, medical or investigative purposes. My images may be altered, manipulated or revised as deemed necessary by my physician. My images may be shared with colleagues or other entities but my personal information will not be shared unless I specially advise such.

Notice of privacy practices

My signature below indicates I have read and/or received a copy of the Notice of Privacy Practices from Foot and Ankle Doctors, PC.

Signature _____ Date _____

Patient Name _____ DOB _____ Acct # _____