LAKES FOOT & ANKLE ASSOCIATES

G. DANIEL SHANAHAN IV, DPM ◇ JENNIFER PETRONELLA, DPM

Our staff wishes to welcome you to the office. Please answer these questions to help us become better acquainted. If you need any help, please ask.

NAME: _____

ADDRESS: _____

_____

_____

City State Zip

SEX: ☐ M ☐ F AGE: _____ Birth date: _____

Home Phone #: _____

Alternate Phone #: _____

Cell / Work / Other _____

E-Mail Address: _____

Soc. Sec. # _____

Occupation: _____

Employer: _____

Employer Address: _____

Can you be reached at work? Yes No Best Time? _____

Work #, if not listed above: _____

NEXT OF KIN (**Blood Relative**)

Name: _____
Relation: _____
Home Phone: _____
Employed By: _____

In case of emergency, contact:

Name: _____
Phone #: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

_____

MEDICAL HISTORY

Please circle "yes" or "no" if you have/had any of the following:

Anemia	Yes	No
Angina	Yes	No
Arthritis	Yes	No
Artificial Valves / Joints	Yes	No
Asthma	Yes	No
Back Problems	Yes	No
Bleeding Disorders	Yes	No
Cancer	Yes	No
Chest Pain	Yes	No
Circulatory Problems	Yes	No
Diabetes	Yes	No
Eye Problems	Yes	No
Gout	Yes	No
Heart Disease	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Liver Disease	Yes	No
Respiratory Disease	Yes	No
Sleep Apnea	Yes	No
Stroke	Yes	No
Tuberculosis	Yes	No

Family Doctor: _____ City _____

Date of Last Visit: _____

Have you had a FLU shot? **Y or N** Date of shot: _____

65 or older – Pneumonia Shot? **Y or N** Date of shot: _____

Please list your medications: _____

_____

_____

Vitamins, Herbals, Supplements? _____

Please list any DRUG ALLERGIES? _____

_____

Other Allergies? _____

Please list any recent surgery: _____

_____

Do you smoke? Yes No How many years? _____

Shoe Size: _____ Height: _____ Weight: _____

Previous podiatrist (if any): _____ Date of last visit: _____

Please list any previous foot problems: _____

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? _____

I hereby give my permission to Dr. Shanahan, Dr. Petronella and any associates to administer treatment as may be deemed necessary in the diagnosis and/or treatment of my foot condition(s). Additionally, I authorize the release of any medical information necessary for the processing of insurance claims.

DATE: _____ SIGNATURE: _____

Lakes Foot and Ankle Associates / Lakes SurgiCare Center

PATIENT RESPONSIBILITIES

1. All patients are responsible for behavior that shows respect and consideration for other patients, family, visitors, and personnel of the Facility.
2. All patients are responsible for assuring that the financial obligations for health care rendered are paid in a timely manner.
3. All patients are responsible for accepting consequences of their actions if they should refuse a treatment or procedure, or if they do not follow or understand the instructions given them by the doctor or their health care team member.
4. All patients have the responsibility of providing the Facility, to the best of their knowledge, with an accurate and complete medical history about present complaints, past illnesses, hospitalization, surgeries, existence of advance directives, medications, and other pertinent data.
5. All patients are responsible for following the plan of treatment recommended by the doctor primarily responsible for the patient's care and/or other personnel authorized by the Facility to so instruct patients.
6. All patients are responsible for notifying the Facility of any change in their condition.
7. All patients are responsible for keeping their appointment for any scheduled procedure. If they anticipate a delay or must cancel the scheduled procedure, it is their responsibility to notify the Facility as soon as possible.
8. All patients are responsible for carrying out their pre-operative orders, if applicable, as supplied by the Facility.
9. All patients are responsible for the disposition of their valuables, as the Facility does not assume his responsibility.

I understand what my responsibilities are at the Facility and I will comply with them.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

NOTIFICATION TO PATIENTS

Disclosure of Ownership:

A corporation formed by Dr. Shanahan owns this facility. He has become an owner as a result of his commitment to quality healthcare and to provide better services to his patients.

Please be advised of the following:

- The facility may have a financial relationship with your physician as indicated above.
- A schedule of typical fees for services provided by the facility may be available at your request.
- You may have the right to choose where to receive services including an entity in which your physician may have a financial relationship. **X _____ (Initial)**

Patient Rights and Responsibilities:

- I have been informed of my Patient Rights and Responsibilities **X _____ (Initial)**

Advance Directives: (End-of-Life Instructions/ Too incapacitated to make a decision)

- I have been informed of my rights to formulate an Advance Directive and understand that I am not required to have an Advance Directive in order to receive medical treatment in this health care facility.
- I understand that it is the policy of this surgery center to resuscitate all patients that require resuscitation in order to maintain their vital functions.
- I understand that in the case of a medical emergency that I may be transferred to the local hospital.

X _____ (Initial)

- **Please check one of the following statements**:

	I have formulated an Advance Directive
	I have NOT formulated an Advance Directive

YOUR CONFIDENTIAL COMMUNICATIONS

Persons whom we can contact regarding your treatment, care, appointments, or financial arrangements:

Answering machine/voice mail at (phone number) _____

Spouse (name) _____

Children (name) _____

Care Giver (name) _____

Power of Attorney (name) _____

Lawyer (name) _____

Institutions (disability, work, etc.) _____

Other (name(s)) _____

If no one is listed in this section we will only be able to speak to you regarding your personal health information.

I have received a copy of Lakes Foot and Ankle Associates Notice of Privacy Practices with an effective date of August 1, 2018.

Signature of Patient _____ Date _____

Lakes Foot and Ankle Associates

Lakes SurgiCare Center

Financial Policy

Thank you for choosing us as your foot and ankle specialist. We share your concern regarding the rising costs of healthcare. Because of this, we have established financial policies which are necessary to help hold down the overall cost of your care. We are committed to your treatment being successful. Please understand that payment of your bills is considered part of your treatment. **All copays and deductibles are due at the time of service unless prior arrangements have been made**. We accept cash, check, money order, Visa, MasterCard, Discover, and American Express.

Insurance

Due to the number of insurance companies, it is impossible for us to be acquainted with each individual policy's guidelines. We ask that you understand your particular policy.

The following are some common terms associated with insurance:

- EOB – Explanation of Benefits – This is the statement from your insurance company of what they have allowed / paid
- Deductible – The amount you are responsible for each year prior to any payment made by your insurance company
- Copay – A set fee you are responsible for at each office visit / procedure (example $20.00)
- Co-Insurance – A percentage of the services rendered not paid by your insurance company
- R & C – Reasonable and Customary – The amount your insurance company decides they will pay for any specific procedure. (The amount varies for each insurance company, therefore we have set our fees at or below the nations average.)
- Allowable / Allowed Amount – The amount your insurance company decides they will pay for any specific procedure.
- HSA – Health Savings Account – An account meant to be used to pay your copay or deductible expenses from, generally an account into which you deposit funds through your employer or one that is self-funded

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor and Lakes SurgiCare Center directly. Although we do not participate with all insurance programs, we will process and submit your insurance claims. Normally, you will only receive a bill from us once your insurance company has paid.

We send your insurance claim within one week of services. However, if your insurance company does not pay, or we have not heard from them within 90 days, you will receive a statement from us, as we will assume your insurance company has made payment to you directly. Please remember that it is your responsibility to promptly answer any requests for information from your insurance company which might hold up processing of your claim. Most insurance companies will send you an EOB within 45 days. If you have not heard from them we encourage you to contact them to determine the status of your claim.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered" or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain *responsible for charges to any service rendered*. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

You must inform the office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

If you have two medical insurance plans, it is your responsibility to inform us which plan is your primary (first), and which is your secondary (second). You must inform us if one or both insurance plans change or are no longer effective. We will gladly bill the secondary insurance for you.

Fees and Payments

In order to control costs, payment for all copays and deductibles is expected at the time services are performed. If you are unable to do so, please discuss your situation with the billing manager or facility director so that special arrangements can be made. If arrangements have not been made and you are unable to pay your copay, a $15.00 billing fee may apply. We will make every effort to accommodate unusual circumstances that make your financial obligations difficult to fulfill. If you are suddenly going through financial hardship, please contact the facility director to discuss your situation.

The fees for evaluation and treatment vary depending upon the complexity of your condition and the treatment required.

Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance due on your account at this office.

_____ (Initials on page 2 of 3 denote my signature is for all pages)

There are certain procedures or items that require prepayment or deposit. You will be informed in advance if your procedure / item is one of those. In that event payment will be due one week prior to the procedure and deposit will be due at the time of ordering.

As a courtesy to our patients, you are welcome to have your credit card or HSA account number on file with us. If you are going to receive a bill from us we will contact you to let you know the amount and ask if you would like it placed on your card. Please ask for a copy of our payment agreement if you would like this service.

There is a $40.00 service fee for all returned checks. Your insurance company will not cover this fee.

Additional charges may be incurred for copies of your records, X-rays, etc. You will be notified of any charges prior to services rendered.

If you have any questions regarding your treatment, your account or our office policies, please phone during business hours. We will see that you are referred to the staff person that is most qualified to answer your questions.

I understand the financial policy of Lakes Foot and Ankle Associates / Lakes SurgiCare Center and agree to all the terms and conditions.

_____ _____

Signature of Patient / Guardian Date

_____ _____

Signature of Witness Date

Lakes Foot and Ankle Associates / Lakes SurgiCare Center would like to thank you in advance for taking the time to complete this short form. We apologize for any inconvenience.

Electronic Health Records (EHR) serve as an important facilitator for collecting patient demographic data. The 2009 economic stimulus bill and the 2010 health system reform bill both strongly encourage demographic data collection in medical facilities.

Due to the recent government initiatives to promote the use of electronic health records and to achieve compliance with Meaningful Use, the reporting of the patient's racial background is now a requirement. Please complete the following information regarding the patient who is being seen today.

If you are uncomfortable answering this question, you may choose: "I choose not to answer this question."

Patient's Name: _____

Date: _____

How would you describe your / the patient's race?

- ☐ White (peoples of Europe and The Middle East)
- ☐ Black or African American
- ☐ Native American Indian, including Alaska
- ☐ Native Hawaiian or Pacific American
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Other _____
- ☐ Two or more races
- ☐ I choose not to answer this question.