PEDIATRIC FOOT & ANKLE

DATE: _____/_____/_____

PATIENT NAME: _____ _____ _____ DATE OF BIRTH:_____/_____/_____ SEX: M F

LAST FIRST MI

HOME ADDRESS:_____ CITY/STATE/ZIP:_____

PREFERRED PHONE NUMBER:_____ MAY WE LEAVE A MESSAGE? : YES NO ALTERNATE

PHONE NUMBER:_____ MAY WE LEAVE A MESSAGE? : YES NO

EMAIL ADDRESS:_____ TEXT REMINDERS : YES NO

PRIMARY LANGUAGE:_____ HOW DID YOU HEAR ABOUT US? _____

PARENT INFORMATION

PLEASE CIRCLE ONE:

MOTHER STEP-MOTHER LEGAL GUARDIAN

NAME:_____

CELL#:_____

WORK#:_____

DATE OF BIRTH:_____/_____/_____

EMPLOYER:_____

PLEASE CIRCLE ONE:

FATHER STEP-FATHER LEGAL GUARDIAN

NAME:_____

CELL#:_____

WORK#:_____

DATE OF BIRTH:_____/_____/_____

EMPLOYER:_____

EMERGENCY CONTACT INFO:

NAME/PHONE#:_____ RELATIONSHIP:_____

NAME/PHONE#:_____ RELATIONSHIP:_____

PEDIATRICIAN:_____ OFFICE:_____ PHONE:_____

PHARMACY:_____CROSS STREETS:_____PHONE:_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:_____

ADDRESS:_____ CITY/STATE/ZIP:_____

MEMBER ID#:_____ GROUP#:_____

POLICY HOLDER NAME:_____ DOB:_____/_____/_____

RELATIONSHIP TO PATIENT:_____

SECONDARY INSURANCE COMPANY:_____

ADDRESS:_____ CITY/STATE/ZIP:_____

MEMBER ID#:_____ GROUP#:_____

POLICY HOLDER NAME:_____ DOB:_____/_____/_____

RELATIONSHIP TO PATIENT:_____

PATIENT NAME:_____

DOB:_____/_____/_____

MEDICAL HISTORY

PLEASE LIST ALL KNOWN ALLERGIES:

_____ _____

_____ _____

_____ _____

_____ _____

CURRENT DAILY/SEASONAL MEDICATIONS AND DOSAGE:

_____ _____

_____ _____

_____ _____

_____ _____

PATIENT HEIGHT: _____ PATIENT WEIGHT: _____ PATIENT SHOE SIZE: _____

WHAT AGE DID YOUR CHILD:

CRAWL:_____ | STAND: _____ | WALK: _____

MEDICAL CONDITIONS/ILLNESSES

☐ ARTHRITIS	☐ ASTHMA	☐ ADD/ADHD
☐ AUTISM	☐ BONE / JOINT PAIN	☐ BLEEDING
☐ CEREBRAL PALSY	☐ CONGENTIAL HEART DISEASE	☐ CYSTIC FIBROSIS
☐ DIABETES	☐ DOWN SYNDROME	☐ HEART MUMUR
☐ HIP DYSPLASIA	☐ INFECTION BONE / JOINT	☐ LIGAMENT LAXITY
☐ SEIZURES/EPILEPSY	☐ SPINA BIFADA	☐ SPRAIN/DISLOCATION
☐ OTHER _____		

REASON FOR VISIT:_____

WHEN DID PROBLEM FIRST START?_____ DURATION OF PROBLEM:_____

LIST ANY PRIOR TREATMENTS FOR THIS PROBLEM:_____

_____

IF APPLICABLE, HOW DOES YOUR CHILD DESCRIBE THEIR PAIN? PLEASE CIRCLE:

SHARP / DULL / ACHING / BURNING / RADIATING / ITCHING / STABBING

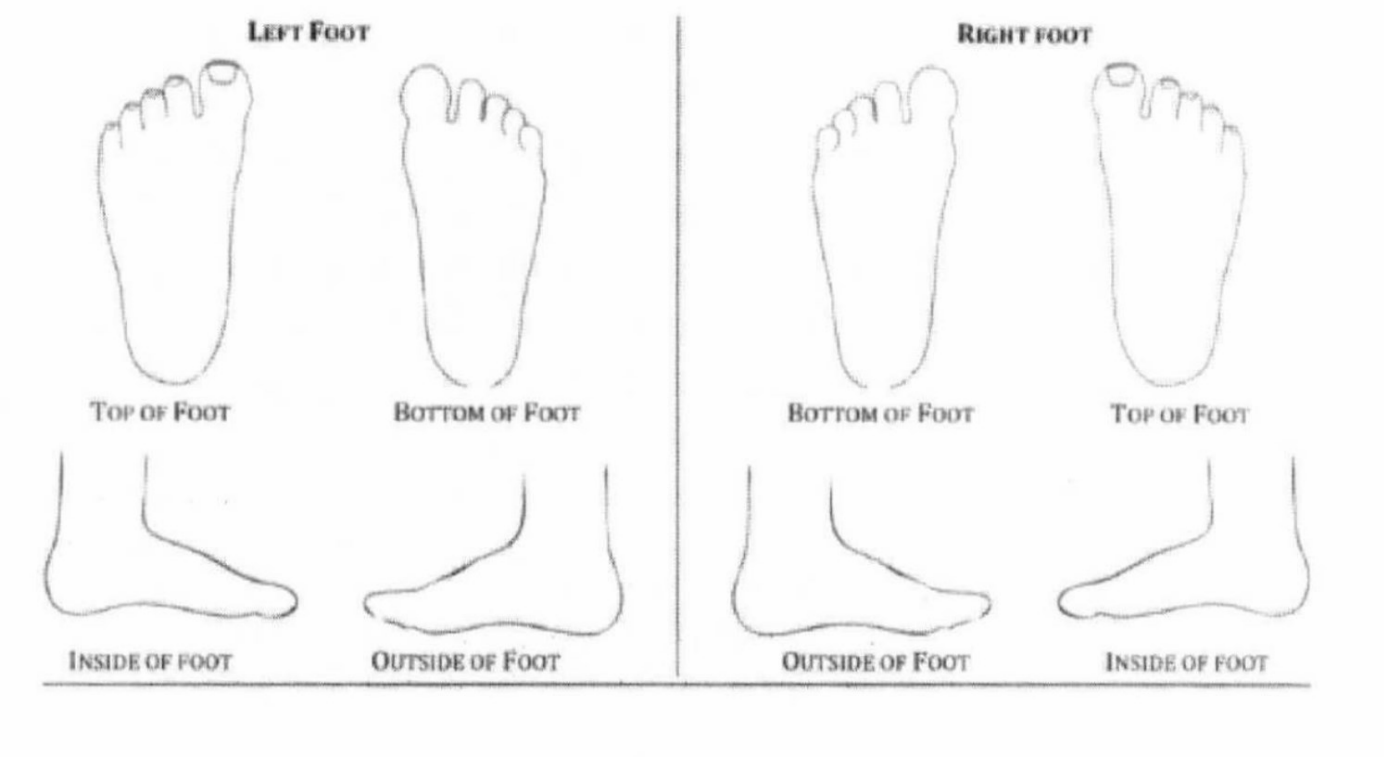
OTHER:_____

PATIENTS NAME:_____
DOB:_____/_____/_____

PLEASE CIRCLE ONE:

PROBLEM CAUSED BY INJURY? **YES / NO**
DOES PROBLEM AFFECT ABILITY TO PARTICIPATE IN SPORTS/ACTIVITIES? **YES / NO**
WHAT MAKES PAIN FEEL WORSE? **STANDING / WALKING / RUNNING**
SINCE THE PROBLEM STARTED HAS PAIN: **STAYED THE SAME / BECAME WORSE / IMPROVED**

USING THE DIAGRAM BELOW, CIRCLE WHERE PAIN/PROBLEM IS LOCATED:



TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTION ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY CHILD'S HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY CHILD'S MEDICAL STATUS OR HISTORY.

_____

Printed name of Parent/ Legal Guardian

_____ _____

Signature of Parent/ Legal Guardian Date

Thank you for choosing Preferred Foot and Ankle Specialists/Pediatric Foot and Ankle as your preferred foot care provider. Your clear understanding of the financial policy agreement is important. Please read carefully and initial/sign where indicated.

1. **Insurance:** As a courtesy we will verify your benefits before your appointment. Coverage, or benefits obtained in the office are not a guarantee of payment or coverage and can change. If your insurance company does not pay the practice within 60 days, the balance will be billed to you.
   Initial: _____

2. **Proof of Insurance:** Patients are responsible for providing accurate and up-to-date insurance information **at the time of service**. Failure to do so may result in claim denial. If a claim is denied due to incorrect or incomplete insurance information, the patient will be responsible for the full claim balance.

   If secondary/tertiary insurance information is not provided at the time of service or prior to claim submission, claims that have already been submitted to the primary insurance will not be refiled or resubmitted to secondary insurance. Once secondary insurance information is received, it will be applied to claims submitted going forward only.
   Initial: _____

3. **Referrals:** If a referral from your primary care physician is required by your insurance plan, it is the **patient's responsibility** to obtain a valid referral prior to the appointment. Appointments without a required referral may be canceled or converted to self-pay.
   Initial: _____

4. **Payment:** All patient financial responsibilities, including copays, coinsurance, deductibles, and self-pay charges, are due at the time of service. Copays cannot be billed and must be collected at check-in, as required by your insurance plan.

   For your convenience we accept cash, check, credit cards, and CareCredit.
   Initial: _____

   Accounts with unpaid balances after 90 days may be subject to our collections process. Accounts forwarded to the collection agency will be responsible for the fee charged by the collection agency (+ 35%) in addition to the amount due in the office.
   Initial: _____

   If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by our billing department.

5. **Non-Covered Services:** Please be aware that some podiatry or routine footcare you receive may be a non-covered service or not considered medically necessary by your insurance company. Any

service determined not covered by your plan will be patient responsibility.
Initial: _____

6. **Durable Medical Equipment (DME)** is often not covered by insurance. Our office verifies coverage for **some, but not all, DME products** that may be dispensed prior to your visit. Verification is not a guarantee of payment, as coverage and reimbursement are ultimately determined by your insurance carrier.

   If your insurance plan does not cover DME, or if coverage is limited or denied, the patient is responsible for the self-pay cost or any portion not covered as determined by your insurance plan.
   Initial: _____

7. **Pediatric Patients:** The accompanying parent or adult is responsible for any copays, deductibles or coinsurance,and/or balances **at the time of appointment. Please refer to our Divorced or Separated Parents Policy if applicable.**
   Initial: _____

8. **Missed Appointment Policy**: We kindly request at least 24 hours' notice for any appointment cancellations or rescheduling. Failure to provide proper notice may result in a **$75 missed appointment fee**.
   Initial: _____

   Patients who repeatedly reschedule appointments may be required to submit a **$50 deposit** to secure future appointments. After **three (3) missed appointments or late cancellations**, the practice reserves the right to discharge the patient from the practice.
   Initial: _____

9. **FMLA/Disability**: Completion of FMLA, disability, or other administrative forms—**excluding work notes and school notes**—is subject to a **$25 processing fee**. The standard turnaround time for these forms is **one (1) week**.
   Requests requiring expedited completion will incur an **additional $25 rush fee**.
   Initial: _____

   I have fully read and understand the financial policy set by Preferred Foot and Ankle Specialists, and agree that the terms of this financial policy may be amended by the practice at any time without prior notification.

_____
Printed name of patient or guarantor

_____ Date:_____
Signature of patient or guarantor

ACKNOWLEDGMENT OF PRIVACY PRACTICES

THE PRIVACY OF YOUR MEDICAL RECORDS AND PERSONAL INFORMATION IS IMPORTANT TO US. DOCUMENTATION OF YOUR INFORMATION AND MEDICAL TREATMENT/ SERVICES RENDERED ARE CREATED TO PROVIDE YOU WITH QUALITY CARE AND COMPLY WITH HIPAA GUIDELINES. PREFERRED FOOT AND ANKLE SPECIALISTS/ PEDIATRIC FOOT AND ANKLE MAY DISCLOSE INFORMATION FOR TREATMENT, OR TO HEALTHCARE PERSONNEL FOR THE PURPOSE OF CARE AND TO OBTAIN ANY AUTHORIZATION/PRE-CERTIFICATIONS.

I ACKNOWLEDGE THAT A FULL COPY OF PREFERRED FOOT AND ANKLE/PEDIATRIC FOOT AND ANKLES PRIVACY PRACTICES IS AVAILABTE ON THEIR RESPECTED WEBSITES/OFFICE CAN PROVIDE A HARD COPY AT MY REQUEST.

_____ _____

PATIENT NAME (please print) Date

_____

Parent/Guardian/Legal Representative

_____

Signature

ANY INFORMATION YOU DO NOT WISH TO DISCLOSE MUST BE SPECIFIED IN WRITING. ANY INFORMATION BEING REQUESTED TO BE RELEASED TO ANYONE BESIDES A REFERRING/TREATING PHYSICIAN MUST BE SUBMITTED TO US IN WRITING

PLEASE LIST THE NAMES OF THOSE THAT YOU GIVE OUR OFFICE PERMISSION TO SPEAK WITH OR OBTAIN COPIES OF YOUR MEDICAL RECORD/MEDICAL CONDITION.

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

_____

Signature of Patient/Guardian

Consent for Treatment of Minor

Patient's Name: _____

Date of Birth: _____/_____/_____

I, the undersigned, parent/guardian of _____, a minor, do hereby authorize and direct Pediatric Foot & Ankle to provide care.

Initials: _____

Consent for Parents or Guardians for Authorized Persons

As the biological parent or stepparent/guardian of _____, I am granting permission for the below listed person(s) to bring my child in for treatment and or care

PLEASE SELECT ONE OF THE FOLLOWING CHOICES:

_____ Initial – I am granting full permission, meaning the below-listed person(s) will be allowed to agree to treatments, and know all heath history pertaining to my child.

_____ **Initial** – I am granting permission, meaning the below-listed person(s) is only allowed to bring in, and will have access to all health history, but not allowed to agree to treatment without my direct consent.

_____ **Initial** – I am granting limited permission, meaning the below-listed person(s) is allowed to bring my child into the office, but is not allowed access to any medical information or treatment of my child. I will be informed of the visit results, and I will be notified prior to any treatment for my child.

Please list person(s) here

_____

_____

Consent to leave voicemail

I am granting to Pediatric Foot & Ankle to leave phone messages regarding my child's medical health to the number(s) provided on the registration form. This consent will remain in effect until rescinded in writing.

_____

Parent/Guardian Signature Date

VIDEO/PHOTO RELEASE FOR MINORS

PEDIATRIC FOOT & ANKLE

Pediatric Foot & Ankle/Preferred Foot & Ankle/Pediatric Orthotics HAS MY PERMISSION TO USE MY CHILD'S PHOTOGRAPH AND/OR VIDEO PUBLICLY TO PROMOTE THEIR MEDICAL PRACTICE, DME PRODUCTS AND THE FOLLOWING:

- Social media platforms (Facebook, Instagram, Tiktok etc.)
- The company website and promotional materials
- Internal training and educational content
- Printed marketing materials
- Newsletters and press releases

I ALSO UNDERSTAND THAT NO ROYALTY, FEE OR OTHER COMPENSATION SHALL BECOME PAYABLE TO ME BY REASON OF SUCH USE. I UNDERSTAND THAT I MAY WITHDRAW MY CONSENT AT ANY TIME BY SUBMITTING A WRITTEN REQUEST. HOWEVER, I ACKNOWLEDGE THAT MATERIALS ALREADY PUBLISHED PRIOR TO MY REQUEST MAY CONTINUE TO BE USED.

☐ I do NOT consent to the use of my image or recordings for any purposes. By signing below, I confirm that I have read, understood, and voluntarily agree to the terms of this consent form.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Name (Printed) _____

Child's Name Printed _____

Phone Number _____

Divorced or Separated Parent Policy

As a courtesy of the care of the child, we ask that parents NOT place our office in the middle of family disagreements. We rely on parents to keep our practice atmosphere calm, professional and caring.

1. **Arizona State law** states that both parents, custodial or non-custodial, have a right to the child's medical records and information about their care. If Mom or Dad requests information, we will honor that request.

   If a Mom or Dad has a court order that restricts the other parents' role, we ask that you provide a copy of that document along with a letter from the attorney that describes our office's legal obligations.

   Initial: _____

2. If a step-parent will be bringing in the child, a legal parent needs to provide written consent. At any time this can be revoked if provided in writing.

3. It is the parent's responsibility to communicate with each other about the child's visit, dates of appointments, treatment recommendations and other relevant issues. We will not call the other parent to discuss the visit or payment due to lack of communication between parents.

4. The parent bringing the child in for an appointment is responsible for all copays and insurance deductible payments at the time of service, even if the other parent is listed as the primary policyholder. Please do not request that our office collect payments from a parent who is not present or may be unaware of the visit.

   Additionally, if there are overpayments or credits on the account, please indicate in writing which parent should receive any refunds.

   Initial: _____

5. In a situation where parents may disagree about medical treatment (e.g whether or not to get orthotics or surgery) we will postpone recommended treatment until there is an agreement between both parents.

6. Other situations that will not be tolerated:
    a. One parent making appointments and the other cancelling.
    b. A parent who asks us to write or say negative things about the other parent.
    c. Parents who fight or create conflict in our offices.
    d. Any other behaviors which interfere with our ability to provide the best possible medical care to all of our patients in a safe, calm environment.
    e. Changing demographic, email address, preferred phone number without notifying other parents.

We sincerely appreciate your trust in us to work together for the best interest of your child(ren)'s health.

_____

Child's Name and DOB

_____

Parent Printed Name

_____

Signature of parent

_____

Date