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:_____

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

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