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www.lowerlimbinstitute.com

Lower Limb Institute
Foot. Ankle. Perihperal Nerve Surgery

PROVIDER: Mina Abadeer

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____ MALE ☐ FEMALE ☐

HOME ADDRESS:_____zIP_____

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ OTHER

ETHNICITY: ☐ AMERICAN INDIAN ☐ ASIAN ☐ BLACK ☐ CAUCASIAN ☐ HISPANIC ☐ REFUSED ☐ UNKNOWN

SOCIAL SECURITY NO. _____

PREFERRED PHONE NO.: ☐ HOME _____ ☐ CELL _____

EMAIL ADDRESS:_____ BEST WAY TO CONTACT YOU: _____

MAY WE LEAVE MESSAGES/TEXT REGARDING OFFICE AND TESTING APPOINTMENTS ON YOUR VOICEMAIL? ☐ YES ☐ NO

HOME ADDRESS: _____

REFERRING DOCTOR:_____

OTHER REFERRING SOURCE: ☐ ADS ☐ FAMILY/FRIENDS ☐ INSURANCE ☐ NEWSPAPER ☐ INTERNET ☐ OTHER

PHARMACY: _____
NAME CROSS STREETS PHONE

PATIENT EMPLOYER INFORMATION

PATIENT'S EMPLOYER NAME: _____
PATIENT'S OCCUPATION: _____WORK PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____ POLICY #: _____
INSURED'S NAME: _____ INSURED'S DOB: _____
INSURED'S ADDRESS: (If different from patient): _____
RELATIONSHIP TO PATIENT: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP_____ PHONE: _____

EXPLANATION OF PAYMENT POLICY & INSURANCE FILING PROCEDURES

I HEREBY PERMIT LOWER LIMB INSTITUTE OF NJ TO RELEASE MEDICAL INFORMATION AND NECESSARY DATA PERTINENT TO THE FILING OF INSURANCE PAPERS IN THE INTEREST OF THE PATIENT NAMED ABOVE AND THE FACILITY. I AUTHORIZE MY INSURANCE CARRIERS TO PAY BENEFITS DIRECTLY TO DR. MINA ABADEER DPM, PC OF NJ ON ANY UNPAID SERVICES FILED ON MY BEHALF BY DR. MINA ABADEER DPM, PC OF NJ. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT TO MINA ABADEER DPM, PC FOR CHARGES FOR THE ABOVE PATIENT, REGARDLESS OF MY INSURANCE COVERAGE. I ALSO UNDERSTAND THAT MINA ABADEER DPM, PC IS NOT ULTIMATELY RESPONSIBLE FOR COLLECTING MY INSURANCE OR NEGOTIATING SETTLEMENTS OF CLAIMS.

PATIENT'S NAME:_____ DATE:_____

CONSENT FOR RELEASE OF INFORMATION/RECORDS TO REFERRING DOCTOR

PATIENT'S NAME:_____ DATE:_____

I HEREBY GIVE MY PERMISSION FOR FOOT & ANKLE CENTER OF ARIZONA TO RELEASE OR DISCLOSE TO:

_____

(Name of Doctor, Hospital, Agency, etc.)

THIS CONSENT IS SUBJECT TO REVOCATION AT ANY TIME IN THE FORM OF WRITTEN NOTICE FROM ME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON, OR WITHOUT REVOCATION, WILL EXPIRE ON _____ (THIS IS NOT TO EXCEED ONE YEAR).

SIGNATURE OF PATIENT: _____ DATE: _____

ADDITIONAL PEOPLE WHO MAY RECEIVE MY PROTECTED HEALTH INFORMATION

BESIDES THE PERSON LISTED AS MY EMERGENCY CONTACT, I AUTHORIZE THE FOLLOWING ADDITIONAL PEOPLE WHO MAY RECEIVE MY PROTECTED HEALTH INFORMATION. I UNDERSTAND I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY GIVING WRITTEN NOTIFICATION TO THIS OFFICE.

THESE PEOPLE MAY RECEIVE MY PROTECTED HEALTH INFORMATION:

NAME: _____ DATE OF BIRTH:_____

RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ CHILD ☐ PARENT ☐ OTHER

NAME: _____ DATE OF BIRTH:_____

RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ CHILD ☐ PARENT ☐ OTHER

SIGNATURE OF PATIENT: _____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY WHICH IS LOCATED ON THE OFFICE WEBSITE, AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOOSE) AND UNDERSTAND THE NOTICE.

_____ _____

PARENT OR AUTHORIZED SIGNATURE DATE

_____

PRINT NAME

PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank your for choosing the Foot & Ankle Center of Arizona for your care. This financial policy is an important part of your care. Due to increased insurance company demands, we ask you to read and agree to the following provisions:

REFERRALS – If your insurance plan requires a referral from your primary care physician, it is **YOUR** responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not obtain your referral, you will be responsible for the visit charges in full at the time of service.

APPOINTMENTS – As a courtesy, we attempt to contact every patient to remind them of their appointment. We kindly ask you to notify us 24 hours in advance in the event you cannot keep your appointment. A $50 fee will be incurred by you in the event of a NO-SHOW or a cancellation made less than 24 hours before your appointment time.

INSURANCE – Your insurance policy is a contract between you and the insurance company. As a courtesy, we will file your insurance claim for you. This allows the insurance company to pay the doctor's office directly.

CO-PAYMENTS & DEDUCTIBLES – Our policy is to collect your portion of the insurance designated co-payment/co-insurance/deductible payments at the time of service. Please be prepared to pay at your visit. We accept VISA, MASTERCARD, AMEX, DISCOVER, CASH, OR CHECK.

OUT OF NETWORK BENEFITS – If we do not participate with your plan but you would like to be treated in our office, we will send a courtesy bill to that carrier on your behalf. Patients are responsible for co-pays, co-insurance and deductibles at the time of the service. A paid receipt will be provided to you to submit to your insurance company. Should your insurance not pay the claim, you will be responsible with the full amount due. If you receive a payment from the insurance company directly, please forward it to our office if you have an outstanding balance.

SERVICES NOT COVERED BY YOUR INSURANCE PLAN – Services not covered by your insurance plan are your responsibility and are to be paid in full at the time services are provided.

PRIVATE PAY PATIENT – If you have no insurance coverage, full payment is expected at the time of service.

SURGERY PATIENTS – Surgical procedures might require a pre-payment of deductible and co-insurance payments if applicable. You will be informed if this applies to your surgery. Surgery Date Change/Cancellation Fee is $250.00 after your surgical consultation.

DELINQUENT ACCOUNTS – Statements are mailed out on a monthly basis. We request that your balance is paid off within 30 days. Past due accounts are subject to collection proceedings without further notice if unpaid after 90 days. In the event your account is turned over to collections, you are responsible for all associated collection costs and late fees.

RETURNED CHECKS – Returned checks are subject to a $25.00 fee and all future payments need to be made by cash or a valid credit/debit card.

LABORATORY FEE – Laboratories bill separately for their services. Any Lab services that are not covered by your insurance will be your responsibility.

ADDRESS AND INSURANCE CHANGES – Please let us know if you have changes in your address, phone numbers, insurance, etc. so that your information is always current in our records.

AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR - Patients under the age of 18 (minors) must be accompanied by a parent/legal guardian unless prior arrangements have been made. In the event that the accompanying adult is not the parent/legal guardian, Consent to Treat Form must be filled out. This can be found on our website. The person bringing in the child for medical treatment will be held responsible for payment at the time services are rendered.

DIVORCE/CUSTODY - Our policy is to hold the parent who brings in the child for medical treatment responsible for payment at the time of service. Our office does require documentation from the court for all legal matters that relate to your child's care; *i.e.*, custody, medical decisions, medical record access, etc.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY AND I AGREE TO THE TERMS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED IN THE EVENT MY INSURANCE DENIES PAYMENT AFTER A CLAIM HAS BEEN SUBMITTED BY MINA ABADEER DPM, PC. I UNDERSTAND THAT MY INSURANCE IS AN ARRANGMENT BETWEEN MYSELF AND MY INSURANCE COMPANY, AND THAT IT IS MY RESPONSIBILITY TO UNDERSTAND MY BENEFITS.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY:

_____ DATE:_____

HISTORY AND INTAKE FORM

Please fill out the following confidential form for our records

PATIENT NAME: _____ DATE OF BIRTH: _____ SHOE SIZE _____

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ OTHER HEIGHT _____ WEIGHT _____

INSURANCE COMPANY:_____ POLICY #_____ PHONE:_____

CURRENT FOOT OR ANKLE PROBLEM: _____

_____

NAME OF PRIMARY PHYSICIAN: _____ PHONE:_____

NAME OF FORMER PODIATRIST/ORTHOPEDIST: _____

WHAT CONDITIONS WERE YOU TREATED FOR? _____

_____

MEDICAL HISTORY

☐	DIABETES	☐	EPILEPSY/SEIZURES
	☐ TYPE I	☐	EPILEPSY/SEIZURES
	☐ TYPE II	☐	FOOT PROBLEMS
☐	THYROID DISEASE	☐	HIGH BLOOD PRESSURE
☐	VASCULAR/CIRCULATORY DISEASE	☐	HIGH CHOLESTEROL
☐	HEART DISEASE	☐	BLEEDING DISORDERS
☐	STROKE	☐	CANCER
☐	HEART ATTACK		☐ TYPE:
☐	GOUT	☐	ANEMIA/BLOOD DISEASE
☐	LIVER DISEASE	☐	ASTHMA
☐	ARTHRITIS	☐	BRONCHITIS
☐	IMMUNE DISEASE (HIV, AIDS)	☐	ACID REFLUX
☐	DEPRESSION	☐	STOMACH ULCER
☐	ANXIETY		

MEDICATIONS

(Please include dosage and frequency of each)

1. _____ 6. _____
2. _____ 7 _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

ALLERGIES

(Penicillin, Novocaine, Tape, etc.)

1. _____ 4. _____
2. _____ 5 _____
3. _____ 6. _____

SURGERIES & HOSPITALIZATIONS

(Describe procedure, year, any complications)

1. _____ 4. _____
2. _____ 5 _____
3. _____ 6. _____

SOCIAL HISTORY

OCCUPATION: _____

TOBACCO: ☐ YES ☐ NO IF YES, HOW LONG? _____ HOW MUCH? _____

ALCOHOL: ☐ YES ☐ NO IF YES, HOW LONG? _____ NO. OF DRINKS DAILY _____

ILLICIT DRUGS: ☐ YES ☐ NO IF YES, HOW LONG?_____ HOW MUCH? _____

FAMILY HISTORY

	MOTHER ☐ Living ☐ Deceased	**FATHER** ☐ Living ☐ Deceased
Diabetes		
High blood pressure		
Heart disease		
Stroke		
Mental Illness		
Cancer		
Gout		
Foot problems		
Other		

INTAKE FORM

(For back office staff only)

LOCATION OF PAIN: RIGHT OR LEFT HEEL ANKLE FOOT TOES

DESCRIBE PAIN: SHARP DULL SORE BURNING ACHING THROBBING

DEGREE OF PAIN: 1 2 3 4 5 6 7 8 9 10

LOCALIZES OR RADIATES FROM _____ TO _____.

SETTING: AM UPON RISING PM WEIGHT-BEARING OR NON-WEIGHT-BEARING

IN SHOES / OUT OF SHOES / NO DIFFERENCE

IS PAIN: GETTING BETTER? GETTING WORSE? STAYING THE SAME? INTERMITTENT? CONSTANT?

WHAT HAS BEEN DONE FOR THE PAIN: REST ICING MEDICATIONS SHOE CHANGES

INSERTS OTC PADS PRIOR SURGERY CUSTOM ORTHOTICS