Aurora
Foot & Ankle
Surgical Specialists, LLC

Manx Quayle, DPM
Diplomate, American Board of Podiatric Surgery
Fellow, American College of Foot and Ankle Surgeons
Member, American Podiatric Medical Association

11/2015

Notice

Print Patient Name: _____

This is a medical office which operates legally. We can only accept **legal** names, First and Last. Which means, we cannot enter or address a person with a nick name or a name they personally prefer. Your Identification and Insurance Cards **must** match. If they do not match, the bills may come back to patient responsibility, in full, and filing claims with the insurance will then become a patient responsibility to reimburse themselves. If Aurora Foot and Ankle has your legal name and your insurance has a nickname they will not align, and therefore, your claims will be denied.

Aurora Foot and Ankle bills insurances as a courtesy for patients. However, without the proper information being provided this becomes a much more challenging process.

We thank you in advance for your help with proper legal identification to make all processes smoother for all parties.

Aurora Foot and Ankle Surgical Specialists, LLC.

Authorized Signature: _____Date:_____

Aurora Foot & Ankle Surgical Specialists, LLC

Manx D. Quayle, DPM

Medical History Form

Name: _____ **DOB:** _____ **Date:** _____

Reason for visit: _____

PLEASE COMPLETE THOROUGHLY. IF CONDITIONS DO NOT APPLY, PLEASE CIRCLE N/A.

PLEASE CIRCLE ALL THAT YOU HAVE BEEN TREATED FOR.

HEART: Chest Pain Palpitations Heart Failure Pacemaker
Irregular Heart Rate Valve Replacement Hypertension
High cholesterol Phlebitis Cellulitis Lymphedema
Coronary Artery Disease Bypass Surgery Catheterization
Angioplasty Stent Placement A-Fib **N/A**
Other: _____

LUNGS: Shortness of Breath Emphysema Pneumonia Asthma
Seasonal Allergies Pulmonary Embolism COPD **N/A**
Other: _____

GASTROINTESTINAL: Reflux Disease Hiatal Hernia Hemorrhoids
Abdominal Aortic Aneurysm Gallstones Gallbladder Removal
Appendectomy Colon Resection Hepatitis Bowel Incontinence **N/A**
Other: _____

NEUROLOGICAL: Stroke Brain Injury Migraines Head Injury
Intracranial Hemorrhage Herniated Disk Carpal Tunnel Sciatica
Limb Numbness/Tingling **N/A**
Other: _____

MUSCULOSKELETAL: Fractures Osteoarthritis Neck Pain
Rheumatoid Arthritis Osteoporosis Low Back Pain Scoliosis
Disc Disease Hip Replacement Knee Replacement **N/A**

Other: _____

ENDOCRINE: Diabetes Thyroid Problems **N/A**
Other: _____

MENTAL HEALTH: Depression Anxiety Panic Attacks
Bipolar Schizophrenia SAD **N/A**
Other: _____

CANCER: Location _____ **N/A**
Surgery: _____
Chemo: YES / NO Radiation: YES / NO

MEDICATIONS: **NONE** _____
_____
_____
_____
_____
_____

MEDICINE ALLERGIES: **NONE** _____
_____

SOCIAL HISTORY: Lives with: Spouse Parents Children Alone
Lives In: ___ Story House / Apartment / Townhouse / Mobile Home
_____ Steps In house. Ramp?_____ Elevator? _____
Bedroom and Bathroom on 1st floor? YES / NO
Smoking YES / NO _____Packs Per Day x___years
Alcohol YES / NO Daily or Socially?
Occupation: _____
_____Currently Working _____Not Working _____Retired

DO YOU NEED HELP WITH ANY OF THE FOLLOWING?

Getting in/out of bed?	YES_____	NO_____
Feeding Yourself?	YES_____	NO_____
Dressing Yourself?	YES_____	NO_____
Grooming Yourself?	YES_____	NO_____
Bathing Yourself?	YES_____	NO_____
Using the Restroom?	YES_____	NO_____
Getting in/out of Chairs?	YES_____	NO_____
Getting in/out of Shower?	YES_____	NO_____

DO YOU USE ANY OF THE FOLLOWING? *(PLEASE CIRCLE)*
Cane Wheelchair Walker Crutches Other

ARE YOU **CURRENTLY* EXPERIENCING ANY OF THE FOLLOWING? (Please Circle all that apply)*

Fever Chills Weakness Insomnia Fatigue
Glasses Blurred Vision Double Vision Hearing Aid
Tinnitus Chest Pain Palpitations Shortness of Breath
Cough Nausea Vomiting Diarrhea Constipation
Incontinence Urinary Pain Urinary Burning Depression
Anxiety Rash Ulcerations Recent Surgical Wound
Swollen Glands Increased Bruising/Bleeding

FAMILY MEDICAL HISTORY: Please List Any Medical History That you are aware of for the following family members

Mother: _____ **N/A**
_____
Father: _____ **N/A**
_____
Siblings: _____ **N/A**
_____
Maternal Grandmother: _____ **N/A**
_____
Maternal Grandfather: _____ **N/A**
_____
Paternal Grandmother: _____ **N/A**
_____
Paternal Grandfather: _____ **N/A**
_____

For Office use only:
WT-_____HT-_____T-_____BP-_____P-_____R-_____

Aurora Foot & Ankle Surgical Specialists, LLC

Manx D Quayle, DPM

Registration Form

Patient's Legal Name _____ **SS#**_____ Birthdate_____
First MI Last

Is patient minor *yes ___ no ___* ***if so, name of RESPONSIBLE PARTY/GUARANTOR*** _____

Mailing Address _____
CITY STATE ZIP

Preferred Phone ( )_____ **Message Phone** ( ) _____

Gender: *M – F* **Marital Status***: Married Single Other* **Preferred Pharmacy:**_____

Employer/School: _____**Business Phone** ( )_____

How did you hear about us or who referred you to our office?_____

Race "Census Bureau Categorization" *(Please Circle)* Caucasian/White African American/ Black Chinese Japanese Korean Other Asian American Indian/Alaskan Native Vietnamese Black Hispanic/Latino White Hispanic/Latino Hawaiian/Pacific-Islander Filipino *Refuse

Language Preference if other than English:_____

Emergency Contact Name:_____ **Relationship** _____ **Phone** _____

#1 PRIMARY INSURANCE INFORMATION:****None of this is on the insurance card**********

Insurance Company Name_____Employer:_____

Primary Policy Holders Name _____ SS# _____ DOB _____

Phone Number Of Policy Holder_____ Address Of Policy Holder_____

 # 2 SECONDARY INSURANCE INFORMATION:****None of this is on the insurance card**********

Insurance Company Name _____Employer:_____

Primary Policy Holder Name _____ SS# _____ DOB _____

Phone Number Of Policy Holder_____ Address Of Policy Holder_____

WORKERS COMP or MOTOR VEHICLE INSURANCE INFORMATION*******

Insurance Company Name _____ Phone ( ) _____

Claim # _____ Date of Injury _____ Body Part Injured _____

Adjustor Name _____

****

I understand that if insurance information is provided, my insurance will be billed as a courtesy. I am responsible for my portion of the bill at the time that services are rendered, as well as any remaining balance my insurance company does not cover. I further authorize release of any information necessary to my insurance company to aid in the payment of claims.

I, the undersigned hereby authorize Manx D. Quayle, DPM and Associates to examine me, (Or my Minor Son/Daughter) to administer such treatment as is necessary and to perform such procedures as are considered therapeutically or diagnostically necessary.

****Patient/Guardian Signature**_____ **Date** _____

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FINANCIAL POLICY

Thank you for choosing us for your health care needs. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment in our office.

All patients (parents or guardians) must complete our Patient Information and Financial Policy before seeing the Provider.

- ***ALL COPAY AND COINSURANCE ARE DUE AT THE TIME OF SERVICE.***
- ***AF&ASS is only preferred with Premera Blue Cross Blue Shield.***
- ***Self-Pay Patients: We ask for $250.00 at your first appointment, prior to being seen. And monthly payments on your account thereafter.***
- ***We will only accept primary and secondary insurances to help assist in the billing process for your visits. Any other coverage would be the patient's responsibility to obtain reimbursements. Effective 5/2015.***
- ***For accounts not actively being paid on - once the balance reaches $500.00 you will be required to pay 50% of this balance prior to being seen for your next appointment. As of 10/1/14.***
- ***If at any point the patient balance is sent to collections, it is our policy to no longer treat, schedule, or prescribe for that patient until the amount in collections has been settled.***
- ***All accounts that have not had ANY payments for 90 days, will have an allowable interest rate applied and will be turned over to collections.***

Regarding Insurance:

It is our goal to provide fast and efficient billing as a courtesy to you. We need your help to accomplish this goal by providing complete and accurate insurance information. ***Knowledge of your deductible and co-pays is your* responsibility.** ***As well as which insurance is primary and secondary. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.*** If your insurance coverage changes for any reason, it is your responsibility to inform our office in a timely manner. If you fail to inform us within 60 days of the change, Aurora Foot & Ankle Surgical Specialists will not be responsible for filing your insurance**. *Please be aware that some, and perhaps all of the services provided may be non-covered services. Some insurance companies reduce or deny benefits saying they are not considered UCR (usual, customary, or reasonable). Please be advised that our fees are based on a national geographic standard and are, in fact UCR for the state of Alaska.***

All deductibles and co-pays are due and payable at the time of service:

***The balance is your responsibility whether your insurance company pays or not. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph*.**

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 determination of usual and customary rates.

Minor Patients:

The adult accompanying a minor, the parents (or legal guardians) of the minor, are responsible for payment.

I have read, understand, and agree to this Financial Policy:

*Patient/Guardian Signature : _____ Date: _____

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Manx D. Quayle, DPM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (**NAME**) _____, acknowledge and agree that I have been ***offered a copy*** of Aurora Foot & Ankle Surgical Specialists, LLC's Notice of Privacy Practices.

_____ Date_____

***Patient/Guardian Signature**

FOR CLINIC USE ONLY

Manx D. Quayle, DPM made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

(Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.)

1626 30th Ave, Suite 202 * Fairbanks AK, 99701 * Phone: (907) 456-FOOT (3668) * Fax: (907) 456-TOES (8637)

Aurora
Foot & Ankle
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Manx D. Quayle, DPM

Billing, Prescription, Verbal Consent Form

Without written permission, we cannot legally release medical/ billing information, or prescriptions to anyone but you, the patient. If you would like to authorize someone to do this for you, please do so on this form.

BILLING AND PAYMENT INFORMATION

I hereby authorize Manx D. Quayle and staff to speak to the person(s) listed below regarding any financial information, including but not limited to billing, payments, and insurance information.

1._____ 2._____

NONE ***(Please Circle "NONE" If there is no one you would like BILLING INFORMATION released to)***

RELEASE OF PRESCRIPTIONS/ORTHOTICS/WORK NOTES/ORDERS

I hereby authorize Manx D. Quayle and staff to release prescriptions that need to be picked up on my behalf to person(s) listed below. **BE ADVISED, PHOTO ID WILL HAVE TO BE PRESENTED AT TIME OF PICK UP **

1._____ 2._____

NONE ***(Please Circle "NONE" If there is no one you would like PRESCRIPTIONS released to)***

VERBAL/ WRITEN RELEASE OF MEDICAL INFORMATION

I hereby authorize Manx D. Quayle and staff to verbally release information regarding my Medical Care/Notes/Appointments and Scheduling etc. to the following person(s)

1._____ 2._____

NONE ***(Please Circle "NONE" If there is no one you would like medical/appointment information released to)***

Please be advised that the above information does not include the retrieval of any Medical Records requested by the patient. Medical Record requests require specific paperwork to be filled out, and unless otherwise specified on that request form we are only authorized to release those records to the patient.

***Patient/Guardian Signature:** _____ Date:_____

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Manx D. Quayle, DPM

February 3, 2011

Attention Patients:

Re: *No Show Policy*, *Effective March 1st, 2011.*

Due to the overwhelming demand for podiatric appointments and our continuously growing wait list, we will be implementing a fee for all no show appointments. If a courtesy call is not received by our office within two hours of your appointment time to cancel or reschedule, a $75.00 No Call, No Show fee will be charged to your account. This will be effective as of March 1st, 2011.

Please be advised that this action is taking place simply as a courtesy to the patients on our waiting list; when an appointment time is saved for a patient and they do not show up as scheduled, that time can always be used for a patient that has been waiting for the next available appointment time with us, and we would like to provide them that courtesy.

If you have any questions, please do not hesitate to speak with the front office staff. Thank you for your consideration regarding this matter.

"I have read, understand and agree to this No Show Policy"

_____

Patient Name

_____ _____

Patient/Guardian Signature Date

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