Arizona Foot Health Center
Michael F Esber DPM, PC
14418 W Meeker Blvd., Suite 205
Sun City West, AZ 85375
(623) 546-4930 Fax (623) 546-5979

Patient Name Patient Name_____Date_____

Please INITIAL next to each section:

_____I hereby give my permission to Dr. Esber to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and /or treatment of my foot condition(s).

_____I hereby authorize Dr. Esber and his staff to prescribe and refill medication through a computerized e-prescribing system. I understand that my physician may be sending my prescriptions electronically, and I have been informed on the e-prescribing process. I also give permission for Arizona Foot Health Center to obtain my medication history from my pharmacy, my health plans, and other healthcare providers.

_____I hereby authorize Dr. Esber and staff to release any information acquired in the course of my examination for insurance purposes.

_____I hereby authorize any physician, hospital or medical care facility to provide all information on my medical history and treatment to Arizona Foot Health Center.

_____I hereby authorize payment directly to the business office of Arizona Foot Health Center on behalf of Dr. Esber for the surgical and /or medical benefits, if any, otherwise payable to me for the services. I understand that I am financially responsible for the charges not covered by insurance..

_____I will notify Arizona Foot Health Center immediately with any insurance, address or contact information changes. Otherwise, I will be held responsible for all actions incurred by inaccurate/outdated information.

_____If eligibility of insurance cannot be verified, or if deductible, out of pocket or co-insurance has not been met, I understand that I will be responsible for the cost of all medical services rendered.

I hereby authorize photocopies of this authorization and my signature to be valid as the original

_____ _____

Patient/Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

The law requires us to keep your medical information private. The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services that you receive in our office. We need this record to provide you with quality care and to comply with certain legal requirements. We may use this information to provide you with medical treatment or services. We may also disclose medical information about you to doctors, nurses, technicians, insurances and other people who are taking care of you.

I acknowledge that I was provided a copy of the Notice of Privacy Practices for Arizona Foot Health Center, and that I have read (or had the opportunity to read if I so chose) and understood the notice.

_____ _____

Patient/Guardian Signature Date

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MEDICARE FINANCIAL AGREEMENT

Patient Name_____Date_____

Thank you for choosing Arizona Foot Health Center. We welcome you and are committed to providing quality care.

Please carefully read the following statement of our financial policy prior to treatment. You will be given an opportunity to speak with one of our staff if you have any questions.

This office accepts Medicare assignment. Medicare will pay our office directly. We will receive 80% of the allowed amount, minus your yearly deductible. Medicare regulations require us to bill and attempt to collect any amounts credited towards your deductible and/or coinsurance (20%).

Medicare determines what we will be allowed for each service. No matter what is listed as our charge, we will receive no more that the Medicare payment, plus your payment of the remaining 20% and any amounts credited towards your deductible. Patients are responsible for payment in full of any supplies or services not covered by Medicare.

Please note that Medicare identifies certain nail treatments, skin treatments, cast bandages and wound dressings as "surgical care". Services that Medicare designates as "surgical" do not necessarily have to require an operation.

We bill all secondary insurances. If you do not have supplemental coverage, we will require that your 20% co-insurance, and any remaining deductible be paid at the time of service. Any non-covered supplies or services must also be paid at the time of service, unless other arrangements are made in advance.

In the event that, after Medicare and any supplemental insurance payments have been made, and your account is left with a balance, that balance will be due from you within thirty (30) days. Statements will be sent out on a monthly basis. If your account is not paid in full within sixty (60) days, interest may accrue at a monthly rate of 1.5%. There will also be a $25 charge for any returned checks.

If you have any questions regarding the above information or any uncertainty regarding your insurance coverage, please do not hesitate to ask. We are here to help you.

My Signature below confirms that I have read the above statement regarding the financial policy and agree to abide by the contents thereof.

_____ _____

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MEDICARE LIFETIME AUTHORIZATION

Patient Name _____

Medicare Number _____

Authorization Period - Lifetime I request that payment of authorized Medicare benefits be made either to me or on my behalf to the provider named above for any claims for services furnished to me by that physician during the effective period of this authorization.

I authorize the above named provider to release any information needed for this claim or any related Medicare claim to the Social Security Administration or its intermediaries or carriers, I further permit a copy of this authorization to be used in the place of the original.

If "other health insurance" is indicated in item 9 of the CMS 1500 claim form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to insurer or agency shown.

I understand that the above named provider accepts Medicare assignment and agrees to accept the charge determination of the Medicare carrier as the full charge, and that I, the patient, am only responsible for any deductibles, co-insurance, and non-covered services or supplies as determined by the Medicare carrier.

_____ _____

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REVIEW OF SYSTEMS

Head to Toe, are you currently experiencing any of the following?

ROS	NORMAL				
GEN	☐	☐ Wt Loss / Gain	☐ Fatigue	☐Fever	☐ Chills
HEENT	☐	☐ Eye Pain	☐ Sore Throat	☐ Congestion	☐ Runny Nose
		☐ Sinus Pressure			
RESP	☐	☐ Shortness of Breath	☐ Cough	☐ Blood in Sputum	☐ Wheezing
		☐ Sputum			
CV	☐	☐ Palpitations	☐ Chest Pain	☐ Sweat/Chills	
GI	☐	☐ Blood in Stool	☐ Abd Pain	☐ Reflux	☐ Nausea/Vomiting
EXT	☐	☐ Joint Pain	☐ Muscle Pain	☐ Extremity Pain	☐ Back Pain
		☐ Pedal Edema	☐ Sciatica		
NEURO	☐	☐ Headache	☐ Numbness	☐ Weakness	☐ Dizzy
		☐ Difficulty Walking	☐ Gait Problem	☐ Tingling	
GU	☐	☐ Pain with Urination	☐ Frequency	☐ Urgency	☐ Vag Bleeding
		☐ Blood in Urine			
SKIN	☐	☐ Skin Discoloration	☐ Lesion	☐ Itch	☐ Rash
		☐ Redness	☐ Abrasions	☐ Dryness	☐ Keloids
PSYCH	☐	☐ Suicidal Ideation	☐ Depression	☐ Insomnia	☐ Anxiety
		☐ Homicidal Ideation			

Patient Name: _____

Patient Signature: _____ Date: _____

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PATIENT NAME:		**DATE OF BIRTH:**
HEIGHT:	**WEIGHT:**	**SHOE SIZE:**
PHARMACY (ADDRESS OR CROSS STREETS)		**Phone number:**
Reason for today's visit:		
Medications: (use other side in necessary)		
Allergies: (Circle all that apply) Please give reaction		**Check here if none_____**
Aspirin / Anti-inflamatory medications / Codeine / Iodine / Local Anestetics / Penicillin / Sulfa / Tape / Latex / Other:		

Check all that apply to present medical conditions:

- ☐ Alzheimer's
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Back Pain
- ☐ Bleeding Disorder
- ☐ Diabetes
- ☐ Easy Bruising
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Low Blood Pressure
- ☐ MRSA
- ☐ Neuropathy
- ☐ Phlebitis
- ☐ Poor Circulation
- ☐ Stomach Ulcers/ GERD
- ☐ Thyroid Condition
- ☐ Varicose Veins

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Family History: (Please select all that apply and indicate which family member)

Arthritis		Flat Feet	
Asthma		Foot Problems	
Bunions		Gout	
Diabetes		Heart Disease	
Epilepsy		High Blood Pressure	
Surgical History: (Procedure, Year, Complications)			

Social History	**Tobacco Use:** Current / Former / Never	**Alcohol Consumption:** Never / Socially / Former

PATIENT DEMOGRAPHIC INFORMATION

All information provided here is strictly confidential
and will not be released without your written consent.

Name *(Last, First,M.I.):*	**Sex:** ☐ M ☐ F	**DOB:**	**SS#**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐Divorced ☐ Widowed	**Spouse Name (parent name if patient is a minor):** *(Last,First,M.I.):*		
Home Phone:	**Cell Phone:**		
E-Mail Address:	**Emergency Contact:**	**Phone Number:**	
Address:	**City, State, ZIP:**		
Alternate Address*(If applicable):*	**City, State, ZIP:**		
Employer:	**Job Title:**		
Race: ☐ Native American ☐Asian ☐Black/ African American ☐Native Hawaiian/Pacific Islander ☐White/ Caucasian ☐ Other	**Ethnicity:** ☐ Hispanic/ Latino ☐ Not Hispanic/ Latino		
Primary Care Provider:	**PCP Phone:**		

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Primary Insurance:	**Secondary Insurance:**

HIPAA ACKNOWLEDGEMENT OF RECEIPT
Notice of Privacy Practices

We at Arizona Foot Health Center are required by law to maintain the privacy of and provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

If you would like a copy of the notice, please ask.

Persons (if any) to whom our office may disclose your medical information:

1. _____ Phone Number:_____Relation To Patient:_____
2. _____ Phone Number:_____Relation To Patient:_____

May we contact you by E-Mail? YES/ NO **May we leave you voice mail messages?** YES/ NO

Patient Signature:_____ **Date:_____**