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____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 Otherwise, I will be held responsible for all actions incurred by inaccurate/outdated information.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.

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FINANCIAL AGREEMENT

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.

It is your responsibility to be aware of your insurance benefits. Exclusions, pre-existing conditions, and terminated health benefits may nullify insurance coverage and transfer financial obligation to the responsible party. Plan specifics, such as deductibles, co-insurance, or non-covered charges, are the responsibility of the patient to be aware of. If you are unclear of your benefits, you will need to contact your insurance carrier for clarification of your coverage.

If you have an insurance carrier which requires referrals or authorizations for care, it is your responsibility, as the patient to obtain any necessary referrals or authorizations to be treated. Please keep track of expiration dates and number of visits allowed, as you will be responsible for obtaining new referrals/authorizations upon their expiration. Many primary Care Physicians are now requiring up to 14 day notice to issues a referral or authorization.

If you are a self-paying patient or wish to submit your own insurance claim, we will require payment in full at the time of service, unless other arrangements are made in advance. For larger balances, we can assist you in obtaining Care Credit assistance.

You are responsible for any unpaid balance on your account. Our office accepts cash, personal checks, and debit/credit cards with the VISA, MasterCard, Discover, or American Express Logo.

In the event that, after your insurance company 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.

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

______________________________ ________________________

Patient/Guardian Signature Date

NO SHOW POLICY

In order to provide the best possible service and availability to our patients, it is our policy to charge $25.00 for any appointments that are not kept and were not cancelled with at least 24 hour notice. Please call us as early as possible if you need to cancel or reschedule your appointment so we can offer that time to another patient. As a courtesy reminder calls are placed 1-2 business days prior to your appointment, but it is still the patient's responsibility to remember their appointment.

I have been notified of the office No Show Policy and I agree to be personally responsible for payment of the No-Show Fee under the terms outlined above. No Show Fees cannot and will not be billed to Medicare or your insurance carrier.

______________________________ ________________________

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PATIENT PRIOR AUTHORIZATION POLICY

It is the responsibility of our insured patients to be aware of any restrictions or requirements stated in their insurance policy. These include deductibles, second opinions, policy exclusions or waived benefits, precertification requirements, and any other restrictions.

As a COURTESY, our office will contact your insurance company for verification of your benefits or pre-authorization requirements. However, a pre-authorization issued by your insurance company simply means that they agree that your office visit, medication, surgery, orthotics or other DME (durable medical equipment) item is medically necessary, however this does not guarantee payment by your insurance company. A standard disclaimer given by all insurance companies that any information given is an estimate of coverage and final determination cannot be made until the claim is received. What this means is:

Verification of Benefits or Prior Authorization does NOT guarantee payment from your insurance company. The patient is ultimately responsible for payment.

Your insurance benefits and the payment we receive are determined by the limits set by your insurance carrier.

It is your responsibility to be aware of your benefits and limits.

A deposit may be required, if you have not met your deductible or out of pocket expenses limit, at the time of service.

By signing below, I understand that I am responsible for the charges not covered and paid by my insurance.

________________________________ __________________________

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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

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

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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:**		
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:**________________