DELAWARE FOOT & ANKLE GROUP
PATIENT REGISTRATION SHEET

Name: _____ Date of Birth: _____
First Initial Last

Address: _____ Gender: M F Marital Status _____
(NO P O BOX)

_____ SS #: _____
City State Zip

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Employer: _____ Occupation: _____

Referral Source: _____

Primary Care Physician: _____ Phone #: _____

Emergency Contact: _____
Name Phone # Relationship

Primary Pharmacy Name & Phone # _____

If the patient is a dependent, please complete below:

Mother's Name: _____ SS#: _____ DOB: _____

Employer: _____ Employer's Phone #: _____

Father's Name: _____ SS#: _____ DOB: _____

Employer: _____ Employer's Phone #: _____

BILLING INFORMATION:

Primary Insurance Co.: _____

ID # _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____ Relationship: _____

Secondary Insurance Co.: _____

ID #: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____ Relationship: _____

Patient Consent for Use and Disclosure of Protected Health Information

Patient Name: _____

In order to comply with the **HIPAA** regulations outlined in our **NOTICE OF PRIVACY PRACTICES**, *Delaware Foot and Ankle Group* will not disclose your medical information without your written permission except as needed for your medical **TREATMENT**, or in order to obtain **PAYMENT** from an insurance company for medical services rendered, or to facilitate the initial healthcare **OPERATIONS** of *Delaware Foot and Ankle Group*.

By signing below, you will be authorizing *Delaware Foot and Ankle Group* to use your protected health information **(PHI)** so that a practitioner will be able to record information in your medical record in order to diagnose your condition and determine the best course of treatment for you. In addition *Delaware Foot and Ankle Group* will be able to provide your medical information to other health care providers involved in your care.

Also, *Delaware Foot and Ankle Group* will use your protected health information to obtain payment from your insurance company. This information will include your diagnosis and a listing of medical services you received.

Lastly, *Delaware Foot and Ankle Group* will continue to call your home or leave a message on an answering machine or in a voice mailbox regarding an appointment, test results, or other treatment issues, or billing and payment matters. If you are unwilling to sign this **Consent for Use and Disclosure of Protected Health Information**,
Delaware Foot and Ankle Group may decline to provide treatment to you.

**** I have read and I understand the information given above. I give my permission to have my protected health information used for my **TREATMENT, PAYMENT**, or other health related **OPERATIONS** of **** *Delaware Foot and Ankle Group*.

Patient/Guardian Signature Date

I have been provided with a copy of *Delaware Foot and Ankle Group's* **NOTICE OF PRIVACY PRACTICES**.

Patient/Guardian Signature Date

Authorization for the Release of Medical Information / Assignment of Benefits

I give permission to Delaware Foot and Ankle Group and its employees, agents, and medical providers to release medical information to insurance carriers, health organizations,governmental agencies, and other entities charged with fiscal responsibility for the payment of medical services rendered to me. I hereby authorize payment of the medical benefits otherwise payable to me,to be directed to the appropriate provider. I consent to have any monies received by the provider of services on my behalf to be applied to my outstanding accounts. I assume full responsibility for payment of any charges for the medical services provided. I understand that any or all of my medical information may be used for blind-data research,in which none of the data will be linked to my identity. I understand that my medical information may be electronically submitted to any or all treating physicians, hospitals,and /or health care entities. I permit a copy of this authorization to be used in place of the original.

Signature Relation to Patient Date

DELAWARE FOOT & ANKLE GROUP

Patient Name: _____ Sex:_____ Height:_____ Weight:_____ Shoe Size:_____

Your Occupation: _____

Do you: sit at your job/how long? _____ stand at your job/how long? _____ sit/stand at your job/how long? _____

Are you required to wear any particular type of work shoe? If yes, what type? _____

Chief Complaint _____

_____

How long has it been bothering you? _____

Any past foot/ankle problems? _____

Is this a work related injury? Y / N Is this injury due to an auto accident? Y / N Could you be pregnant? Y / N

COMPREHENSIVE MEDICAL HISTORY

Do you have or have you ever been treated for any of the following?

Abnormal Bleeding/Healing	Y / N	Diabetes	Y / N	High Blood Pressure	Y / N	Pacemaker	Y / N
Anemia	Y / N	Epilepsy	Y / N	HIV	Y / N	Poor Circulation	Y / N
Arthritis	Y / N	Frequent Infections	Y / N	Intestinal Problems	Y / N	Psychiatric	Y / N
Asthma	Y / N	Gout	Y / N	Kidney Disease	Y / N	Sciatica	Y / N
Bladder Problems	Y / N	Heart Attack	Y / N	Lyme Disease	Y / N	Spinal/Disc Disorder	Y / N
Blood Clots	Y / N	Heart Murmur	Y / N	Lung Disease	Y / N	Stomach Ulcer	Y / N
Cancer	Y / N	Headaches	Y / N	Neurological Problems	Y / N	Stroke	Y / N
Cataracts	Y / N	Hepatitis, Liver Disease	Y / N	Other Heart Conditions	Y / N	Unexplained Weight Loss/Gain	Y / N

Are you allergic or sensitive to any of the following:

Penicillin	Y / N	Sulfa Drugs	Y / N	Iodine or Shellfish	Y / N
Codeine	Y / N	Morphine/Demerol	Y / N	Adhesive Tape	Y / N
Aspirin/Advil/Aleve	Y / N	Novacaine/Lidocaine	Y / N	Latex	Y / N

Other _____

Have you had any surgeries? Y / N If yes, please list below.

_____

_____

_____

Do you smoke: Y / N # of Packs/ Day _____ Have you smoked in the Past? Y / N # of Packs/Day _____

Do you drink alcoholic beverages? Y / N 1 - 2 Drinks/Week 1 - 2 Drinks/Day More than 2 drinks a Day

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance.

SIGNATURE OF PERSON FILLING OUT THIS FORM _____ DATE_____

MEDICATION LIST

Patient Name: _____

DOB: _____

Pharmacy Name and Phone #: _____

List all medications including prescriptions, non-prescriptions, vitamins, and herbal supplements.

Medication	Prescribing Physician	Dosage	Frequency

DELAWARE FOOT & ANKLE GROUP'S PATIENT FINANCIAL POLICY

DELAWARE FOOT & ANKLE GROUP IS COMMITTED TO SERVING OUR PATIENTS WITH CARE AND PROFESSIONALISM. PLEASE UNDERSTAND THAT PAYMENT FOR SERVICES IS PART OF THAT RELATIONSHIP. IF YOU HAVE ANY QUESTIONS ABOUT OUR FEES, POLICIES, OR YOU'RE FINANCIAL RESPONSIBLITIES, PLEASE CALL BILLING AT 302-834-3575.

____ (INITIAL) I AGREE TO BE FINANCIALLY RESPONSIBLE FOR PAYMENTS TO DELAWARE FOOT & ANKLE GROUP, WHERE I AM RECEIVING TREATMENT; AND I AGREE TO ABIDE BY THIS PATIENT FINANCIAL POLICY. SHOULD MY INSURANCE COMPANY, FOR ANY REASON, DENY THE CLAIM FOR MY VISITS OR APPLY ANY PORTION TO MY DEDUCTIBLE, OUT OF POCKET, OR COINSURANCE, I WILL PAY THE BALANCE THAT IS DUE TO DELAWARE FOOT & ANKLE GROUP WITHIN 30 DAYS OF THE FIRST STATEMENT. MY CREDIT/DEBIT/HSA AUTHORIZATION IS ON FILE AND MAY BE CHARGED FOR ANY BALANCES ON ACCOUNT.

____ (INITIAL) INSURANCE CARDS MUST BE PRESENTED AT EVERY OFFICE VISIT. COPAYS AND REFERRALS ARE DUE AT TIME OF SERVICE; IF YOU DO NOT HAVE YOUR COPAY AND VALID REFERRAL IS NOT ON FILE, WE WILL HAVE TO RESCHEDULE THE APPOINTMENT.

____(INITIAL) PAST DUE ACCOUNTS ARE SUBJECT TO COLLECTION PROCEEDINGS. ALL COSTS INCURRED - INCLUDING ADMINISTRATION FEES, COLLECTION FEES, ATTORNEY FEES, AND COURT FEES - SHALL BE YOUR RESPONSIBILITY , IN ADDITION TO THE BALANCE DUE ON YOUR ACCOUNT.

____(INITIAL) THERE IS A SERVICE FEE OF $45.00 FOR ALL RETURNED CHECKS. YOUR INSURANCE COMPANY DOES NOT COVER THIS FEE. THERE IS A 5.00 CONVENIENCE FEE FOR CREDIT/DEBIT//HSA CARDS USED FOR BALANCES LESS THAN 20.00. SUBMIT CHECK OR CASH TO AVOID THIS FEE.

____(INITIAL) I UNDERSTAND THAT MY BENEFITS MAY NOT COVER ALL SERVICES WITH DELAWARE FOOT AND ANKLE GROUP OR MAY DENY PAYMENT FOR SERVICE; I AGREE TO PAY THE BALANCE REMAINING ON MY ACCOUNT AFTER THE INSURANCE CLAIM HAS BEEN PROCESSED.

____(INITIAL) YOU MUST INFORM THE OFFICE OF ANY INSURANCE CHANGES AND AUTHORIZATION/REFERRAL REQUIREMENTS. IN THE EVENT THE OFFICE IS NOT INFORMED, YOU WILL BE RESPONSIBLE FOR ANY DENIED CHARGES.

____(INITIAL) FOR MOST SERVICES PROVIDED IN THE HOSPITAL, WE WILL BILL YOUR HEALTH PLAN. ANY BALANCE DUE IS YOUR RESPONSIBILITY.

____(INITIAL) CERTAIN PROCEDURES/SERVICES MAY REQUIRE PRE-PAYMENT; YOU WILL BE INFORMED IN ADVANCE IF YOUR PROCEDURE/SERVICE WILL REQUIRE PREPAYMENT.

____(INITIAL) IF DELAWARE FOOT & ANKLE GROUP HAS A CONTRACT WITH MY INSURANCE COMPANY, DELAWARE FOOT AND ANKLE GROUP WILL RECEIVE PAYMENTS FROM MY INSURANCE COMPANY FOR COVERED SERVICES. I AGREE TO PAY CO-PAYMENT AND DEDUCTIBLE BALANCES ATTRIBUTED TO THE DATES OF SERVICE OR ANY BALANCE DUE.

____(INITIAL) I AGREE TO PAY ANY BALANCES REMAINING ON MY ACCOUNT UPON RECEIPT OF MY STATEMENT. DELAWARE FOOT & ANKLE GROUP WILL SEND OUT 2 STATEMENTS, IF PAYMENT IS NOT RECEIVED WITHIN 30 DAYS, DELAWARE FOOT & ANKLE GROUP WILL CALL YOU AS A COURTESY. IF NO RESPONSE OR PAYMENT HAS BEEN MADE, WE WILL FORWARDYOUR ACCOUNT TO A COLLECTIONS AGENCY.

____(INITIAL) IF THE REASON FOR MY APPOINTMENT IS RELATED TO A WORK INJURY OR AUTO ACCIDENT, I AGREE TO PROVIDE DELAWARE FOOT & ANKLE GROUP THE CASE NUMBER/ POLICY NUMBER/THE WORKMAN'S COMPENSATION OR INSURANCE CARRIER'S NAME, ADDRESS, OR OTHER CONTACT INFORMATION PRIOR TO MY APPOINTMENT SO THAT DELAWARE FOOT & ANKLE GROUP CAN BILL WORKMAN'S COMPENSATION OR THE AUTO INSURANCE CARRIER FOR MY VISITS. IF I DO NOT PROVIDE THIS INFORMATION PRIOR TO VISIT(S), I AGREE TO PAY ALL CHARGES INCURRED.

I HAVE READ AND I UNDERSTAND DELAWARE FOOT & ANKLE GROUP'S FINANCIAL POLICY. I ACCEPT RESPONSIBILITY FOR THE PAYMENT OF ANY FEES ASSOCIATED WITH MY CARE, FOR ALL THE DATES OF SERVICE, FOR THE YEAR LISTED BELOW.

_____ _____

PATIENT SIGNATURE *DATE*

_____ _____

GUARDIAN SIGNATURE (IF PATIENT IS A MINOR) *DATE*

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE DIRECT PAYMENT OF MY MEDICAL BENEFITS, INCLUDING MEDICAL BENEFITS TO WHICH I AM ENTITLED, TO DELAWARE FOOT & ANKLE GROUP. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS. THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR ONE YEAR FROM DATE OF SIGNATURE. A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL DOCUMENT.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO OBTAIN PAYMENT FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, LATE FEES, INTEREST, ATTORNEY FEES, ADMINISTRATION FEES, AND COLLECTION CHARGES CONSIDERED PATIENT RESPONSIBILITY BY MY INSURANCE COMPANY. I UNDERSTAND THAT IF I AM NOT INSURED, I AM RESPONSIBLE FOR THE CHARGES OF ALL SERVICES PROVIDED TO ME. I AUTHORIZE DELAWARE FOOT & ANKLE GROUP TO DEPOSIT CHECKS RECEIVED ON MY ACCOUNT WHEN MADE OUT IN MY NAME.

I HAVE READ AND UNDERSTAND DELAWARE FOOT & ANKLE GROUP'S FINANCIAL POLICIES; AND I ACCEPT RESPONSIBILITY FOR THE PAYMENT OF ANY FEES ASSOCIATED WITH MY CARE.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

GUARDIAN SIGNITURE (IF PATIENT IS A MINOR) DATE