HAMILTON FOOT AND ANKLE CARE, LLC

9865 E. 116th St. #300
Fishers, IN 46037
(317)-284-8888

Patient Name: ____ **Date of Birth:** ____/____/____
First MI Last

SS#:_______________ **Address:**____

City: ________________________________ **State:** ____________ **Zip Code**: _______________

Cell Phone: (_____) ______ - ________ **Home Phone:** (_____) ______ - ________

Patient's Employer: _____________________ **Employer Phone:** (_____) ______ - ________

Employer Address: ____

City: ________________________________ **State:** ___________ **Zip Code:** _______________

Email: ____

May we contact you via email for appointment reminders? Yes No
May we contact you via text message for appointment reminders? Yes No

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Sex: (circle one) Male Female **Marital Status**: (circle one) M W D S
Race: (circle one) American Indian or Alaska Native Asian Black or African American
Native Hawaiian or other Pacific Islander White or Caucasian Other
Ethnicity: (circle one) Hispanic or Latino Non-Hispanic or Latino **Language:** _______________

Insurance Policy Holder-the person who carries the insurance ____**Same as Patient**

Insurance Plan Name:____

Name: ____ **Date of Birth**: __/___/______
First MI Last

SS#:________________________________

Relationship to Patient: ____________________________ **Phone:** (_____) ______ - ________

Address: ____

City: ________________________________ **State:** ____________ **Zip Code:** _______________

Employer: ______________________________ **Employer Phone:** (_____) ______ - ________

Emergency Contact

Name: ____ **Relationship**: ________________

Cell Phone: (_____) ______ - ________ **Home Phone:** (_____) ______ - ________

Pharmacy Name: _________________________________ **Phone:** (_____) ______ - ________

Address: ____ **City:** _____________ **State:** _______

Reason for today's visit: ____

PERSONAL MEDICAL HISTORY

Check all that apply to you

	Anemia/Blood Disorder		Heart Trouble
	Anxiety/Depression		High Blood Pressure
	Arthritis		High Cholesterol
	Asthma		Kidney Disease
	Blood Clots		Mental Health Disorder
	Cancer		Skin/Connective Tissue Disorder
	Depression		Stomach/Ulcer Disorder
	Diabetes		Stroke
	Epilepsy/Seizures		Thyroid Disease
	Frequent Headache/Migraines		Tuberculosis
	Gout		Other (specify):
	No known active medical problems		

Height: _______Weight: _______Shoe Size: _______ Occupation: _______________________

Family Physician: ________________________________ Phone: _________________________

Has any family member had any of the following? (Please indicate relationship)

☐ No known family history of these conditions

		Relationship			Relationship
	Cancer			Blood Clots	
	Heart Trouble			Diabetes	
	Kidney Disease			High Blood Pressure	
	Tuberculosis			Stroke	
	Asthma			Arthritis	

Mother: Living Deceased Cause of Death______________________

Father: Living Deceased Cause of Death______________________

Social History

Do you smoke currently? ___ Yes ___ No How many packs/day? ____For How long? ____

Have you smoked previously? ___ Yes ___ No When did you quit? _______

Do you drink alcohol currently? ___ Yes ___ No How many drinks/week? ____

Allergies (Please list reaction)

☐ No known allergies

___ Food: ____

___ Medication: ____

___ Environmental: ____

Current Medications (Please list all medications, or provide us a list)

☐ No current medications

____ ____

____ ____

Surgical History (Please list all surgical procedures and year)

☐ No previous surgeries

Type of Surgery	Approximate Date/Year

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing us as your podiatric care. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which must be read and signed by each patient and will remain in effect for all services rendered during your time as a patient at Hamilton Foot & Ankle Care LLC.

INSURANCE CLAIMS:

Your Insurance policy is a contract between you and your insurance company. It is your responsibility to contact your insurance company to verify that Dr. Vogel is a provider in your insurance network. Not all insurance plans cover all services. At the time of your first visit a copy of your insurance card will be taken. If you do not have your insurance card at the time of your visit, you will be given the option to reschedule. Otherwise you will be required to pay *all* charges up front. All co-pays and/or outstanding balances will be collected at the time of service. When we file with your insurance company, you are still required to pay your co-pay at the time of service.

For all surgeries, co-pays, deductibles and co-insurance amounts will be verified with your insurance company, 50% of that balance will be collected within 10 days prior to surgery with the remainder being due at the first post-op visit.

Please understand that you are financially responsible for any unpaid balance for services if you fail to provide complete, current insurance information. We cannot, as a third party become involved in prolonged insurance negotiations, this is your responsibility. Please read all Explanations of Benefits sent to you from your insurance company and call them if you do not understand or have a question.

MEDICARE CERTIFICATION: (INITIAL ONLY IF YOU HAVE MEDICARE COVERAGE)

I certify that the information given by me is applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician who treats me to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers. I request payment or authorization benefits be made to my physician treating me, on my behalf.

____________ (initial here).

METHOD OF PAYMENT:

For your convenience, Hamilton Foot and Ankle, LLC accepts, cash, check, Visa, MasterCard, Discover, and American Express. All returned checks will be assessed a $30.00 fee and all future payments will be expected in cash, money order or credit card.

In the instance of default of payment, I will pay all interest on the balance due together with all collections, finance fees, billing charges, cost of collection fees, attorney fees, and court cost assessed by the court or collection agency.

WORKER'S COMPENSATION:

Worker's compensation will be filed if the patient notifies Hamilton Foot and Ankle Care, LLC upon scheduling the appointment and supplies billing information upon check in. Details of the accident will be required and a worker's compensation form will be completed.

MISSED APPOINTMENT'S

We reserve the right to charge for missed appointments that are not cancelled with a 24 hour notice at the rate of $35.00. Please help us serve you better by keeping scheduled appointments. This fee will be required to be paid in full at your next visit.

I authorize the release of medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing. You herein authorize payment of medical benefits to Hamilton Foot and Ankle Care, LLC when an assigned claim is filed.

Your signature below indicates that you accept, understand and agree to this policy.

_________________________________ _________________________________

Print name of patient **Print name of Parent/Legal Guardian**

Signed: _____________________________ **Date:** ___________________

Patient or Parent/Legal Guardian

Hamilton Foot and Ankle Care, LLC

CONSENT AND AUTHORIZATION TO TREAT

(Please initial each line below)

_______I request and give consent to Dr. Thomas Vogel to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well-being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

_______ I authorize Hamilton Foot and Ankle Care, LLC to access my prescription history from unaffiliated medical providers, insurance companies, and pharmacy benefit managers to help keep my medical record as complete as possible. I understand that my prescription history from other sources may be viewable by the providers and staff within Hamilton Foot and Ankle Care, LLC, and may include prescriptions dating back several years.

_______ I acknowledge that I was provided a copy of the Notice of Privacy Practices **(HIPAA**) (**located in office lobby**) and I have read (or had the opportunity to read if I so chose) and understand the Notice.

_______To the best of my knowledge, all the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a health or personal information change.

My initials above and signature below acknowledge that I understand and accept the terms and conditions of this authorization and agreement. I agree that the information I provided is true and accurate to the best of my knowledge. Further, my signature authorizes Hamilton Foot and Ankle Care, LLC to release medical information necessary to process insurance claims (if any). I herein authorize payment of medical benefits to Hamilton Foot and Ankle Care, LLC when an assigned claim is filed. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to the physician. In the case of default payment, I promise to pay all interest on the balance due together with all collection, attorney and legal fees, court filing fees, and interest assessed by the court or collection agency, to effect collection of this account or future outstanding accounts.

Signature of Patient or Parent/Legal Guardian

____Date____________

Signature of Patient or Parent/Legal Guardian Decline

____**Date**____________

HIPAA AUTHORIZATION FORM for Family Members/Friends

I, ____give permission to Hamilton Foot and Ankle Care, LLC to use the following protected health information, and/or disclose the following protected health information to:

Names(s): ________________________________ ____________________________________

Relationship: ______________________________ ____________________________________

Information to be disclosed (check all that apply):

- ☐ Medical Records
- ☐ Treatment Records
- ☐ Diagnostic Records
- ☐ Appointment Information
- ☐ Other: ____

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations. ***You may decline to give permission to anyone*.** Your refusal to appoint anyone will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization. You may revoke this authorization in writing at any time by sending written notification to Hamilton Foot and Ankle Care, LLC 9865 E. 116th St, Suite 300, Fishers, IN 46037. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

____

Signature of patient or personal representative

Date____________________

_____Decline to give permission (You **must** still sign and date above)

LATE ARRIVALS, MISSED APPOINTMENTS & PAPERWORK POLICY

IF YOU ARE MORE THAN 10 MINUTES LATE FOR YOUR APPOINTMENT, YOU MAY BE ASKED TO RESCHEDULE. IF WE HAVE TIME TO SEE YOU THAT DAY, YOU MAY BE REQUIRED TO WAIT. IF YOU NEED TO COMPLETE PAPERWORK AND HAVE ARRIVED ON TIME FOR YOUR APPOINTMENT, YOU WILL HAVE *10 MINS* TO DO SO. OTHERWISE, YOU MAY BE ASKED TO RESCHEDULE YOUR APPOINTMENT.

****We reserve the right to charge for missed appointments that are not cancelled with a 24 hour notice at the rate of $35.00. Please help us serve you better by keeping scheduled appointments or notifying us in advance ****

THANK YOU FOR YOUR UNDERSTANDING.

Initials (Acknowledging you received this policy) ___________

Appointment Reminder Notification Options

Hamilton Foot and Ankle Care will send appointment reminders via e-mail and also e-mail via the patient portal 3 days before the appointment and again one day before the appointment if you have provided us with an e-mail address.

Hamilton Foot and Ankle Care is now also sending out text message reminders about upcoming appointments 3 days before the appointment and again the day before the appointment if you have provided us with a cell phone number.
Your normal text messaging fees may apply.

_______ I agree to receive appointment reminders via Text Message.
_______ I decline to receive appointment reminders via Text Message.

Please initial one of the options above regarding receiving text messages for appointment reminders.