

FOOT & ANKLE SURGICAL GROUP

10561 Jeffrey's St. Suite 110
Henderson, NV 89052
Tel: 702-456-3668 * Fax: 702-456-6688

Douglas S Stacey D.P.M.
Gerald W. Torgesen D.P.M.
Philip J. Larsen D.P.M.
Jeff Korab D.P.M.
Leonard Franklin D.P.M.

Patient Information

First Name: _____ Last: _____ MI: _____

What name do you prefer to be called? _____

Date of Birth: _____ Social Security #: _____ Marital Status: _____ Gender: _____

Patient's Street Address: _____

City: _____ State: _____ Zip: _____

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

Please check the primary number where you can be reached at for medical reasons: Home Work Cell

Primary Insurance: _____ Member ID: _____ GRP # _____

Secondary Insurance: _____ Member ID: _____ GRP # _____

Employer: _____ Employer Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Physician's Phone: _____

Referring Physician: _____ Physician's Phone: _____

Name of Emergency Contact Person not living with you: _____

Phone: _____ Relationship to Patient: _____

Was this an accident? YES NO Is this a workers compensation claim? YES NO

Guarantor Information- For Parents, Spouse, or Power of Attorney- If Same as Patient Leave Blank

First Name: _____ Last: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Date of Birth: _____

Social Security #: _____ Employer: _____ Relationship to Patient: _____

Medical Information

LIST CURRENT MEDICATIONS- List dosage and why you are taking each medication. Attach a separate list if necessary.

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

LIST PREVIOUS SURGERY OR HOSPITALIZATIONS- List date, type, and any complications.

1) _____

2) _____

3) _____

WHO IN YOUR FAMILY HAS OR HAD

Diabetes _____ Heart Disease _____

High Blood Pressure _____ Cancer _____

Stroke _____ Other _____

Have you Ever Smoked? _____ Drink Alcohol? _____ History of Non-Prescribed Drug Use? _____

ALLERGIES TO MEDICATIONS- List medication and reaction

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SELECT ALL THAT APPLY

Constitution:	<input type="checkbox"/> Good General Health	<input type="checkbox"/> Recent Weight Change	<input type="checkbox"/> Fever	<input type="checkbox"/> Fatigue
Eyes:	<input type="checkbox"/> Eye Disease / Injury	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Glaucoma
	<input type="checkbox"/> Wears Glasses / Contacts			
ENT:	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Tinnitus	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Sinus Problems
	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Mouth Soars	<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Sore Throat
	<input type="checkbox"/> Voice Change	<input type="checkbox"/> Swollen Neck Glands		
Cardio:	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Angina
	<input type="checkbox"/> Palpitations			
Respiratory:	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Spitting Up Blood	<input type="checkbox"/> Coughs	<input type="checkbox"/> Asthma
Gastro:	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Change in Bowel Movements	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> History of Rectal Bleeding	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Heartburn
	<input type="checkbox"/> History of Stomach / Duodenal Ulcers			
Musculo:	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Difficulty Walking	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Stiffness
	<input type="checkbox"/> Muscle Cramps	<input type="checkbox"/> Back Pain		
Skin:	<input type="checkbox"/> Change in Skin Color	<input type="checkbox"/> Change in Nails	<input type="checkbox"/> Rash	<input type="checkbox"/> Itching
Neuro:	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Light Headedness	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Convulsions
	<input type="checkbox"/> Seizures	<input type="checkbox"/> Tingling Sensations	<input type="checkbox"/> Numbness	<input type="checkbox"/> Tremors
	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Head Injury	
Psychiatric:	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Depression	<input type="checkbox"/> Insomnia
Endocrine:	<input type="checkbox"/> Glandular Problems	<input type="checkbox"/> Hormone Problems	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Cold Intolerance		
Hematolic:	<input type="checkbox"/> Slow Healing After Cuts	<input type="checkbox"/> Bleeding Tendencies	<input type="checkbox"/> Anemia	<input type="checkbox"/> Phlebitis
	<input type="checkbox"/> Past Transfusions	<input type="checkbox"/> Enlarged Glands		
Immunological:	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> HIV
	<input type="checkbox"/> Tuberculosis			
Social:	<input type="checkbox"/> Current Smoker	<input type="checkbox"/> Previous Smoker	<input type="checkbox"/> Drink Alcohol	

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PATIENT PRIVACY ACKNOWLEDGEMENT

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. If you would like to review our privacy practices in more detail please ask our staff. A copy is available in the waiting room.

The Provider's Privacy contact Officer for Foot and Ankle Surgical Group is Dr. Philip J. Larsen D.P.M.

I hereby acknowledge that I have been presented this notice of Privacy Practices.

Patient Name (Please Print): _____ Date: _____

Patient Signature: _____

If you would like anyone to have access to your records, please list their names below:

CONSENT TO TREATMENT & FINANCIAL RESPONSIBILITY POLICY

I hereby give permission for the doctors of Foot & Ankle Surgical Group to examine and render medical and / or surgical treatment. I also agree to follow ALL prescribed treatment. I authorize photographs to be taken for medical education purposes. I also authorize the release of any information required or acquired in the course of examination or treatment. Foot & Ankle Surgical Group agrees to provide podiatric medical services for the patient whose name appears below.

It is customary to pay for professional services when rendered. Therefore, all fees are due at the time treatment is provided. As a courtesy, our office will bill your primary insurance for you. A finance charge of 1.5% per month (18% per annum) will be charged on outstanding balances of 90 days (minimum service charge \$1.00). At 90 days, if the undersigned fails to pay the FULL AMOUNT for goods or services rendered, a reasonable collection fee will be assessed and the account will be turned over to a collection agency. There will also be a \$25.00 charge (to you personally, not your insurance provider) if you miss an appointment and fail to notify our office. The undersigned agrees to pay all costs of collection; all court costs and all attorney fees involved in recovering any outstanding balance due on this account.

Insurance may pay all or part of your financial obligation to the Foot & Ankle Surgical Group. However, you are responsible to see that all accounts are completely paid within 90 days. It is very important for you to understand that it is impossible for our office to know what your particular insurance plan will cover, what it will allow, or what it will pay for services we render to you. Many times we won't know this information until after we receive the Explanation of Benefits (EOB) from your insurance company. Therefore, by becoming a patient of the Foot & Ankle Surgical Group YOU assume complete and total responsibility for all charges.

- I understand and accept financial responsibility for payment of all accounts with the Foot & Ankle Surgical Group.
- I do not consent to treatment.
- I refuse to be financially responsible.

Signature of patient or responsible party _____

Patient's Name (Printed) _____ Date _____

IF PATIENT IS UNDER 18 YEARS OF AGE: I hereby authorize treatment for the minor whose name appears above as "patient".

Signature of responsible party _____ Relationship _____ Date: _____

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OFFICE POLICIES

PLEASE READ AND SIGN THE FOLLOWING POLICIES

- I certify that all of the information given by me is correct to the best of my knowledge.
- I hereby authorize direct payment of surgical/medical benefits to Foot & Ankle Surgical Group for medical services rendered. I understand that I am financially responsible for any balance unpaid by my health insurance. All patient balances that remain unpaid for more than 90 days can/ will be referred to a collection agency.
- I understand that if my insurance company does not pay for any medical services rendered, even after prior authorization is given to our office, I will be financially responsible for any remaining balance. Some medical procedures require prior authorization. Our office will obtain any necessary authorizations. A prior authorization from your insurance company is not a guarantee of a payment by your insurance company.
- All co-pays, coinsurance and deductibles are due at the time service is rendered.
- There will be a \$25.00 check fee for all returned/non-sufficient funds/closes account checks. If the check is not settled within 10 days of the date it is issued it may be referred to the District Attorney's Office for collections.
- All prescription refills will be processed within 48 hours of notification, and during Office Hours only. We are unable to refill prescriptions after hours, weekends, or holidays.
- There will be a \$20.00 fee for each time we fill out your FMLA and/Disability forms. We will not accept incomplete forms. You portion must be complete before we can complete the physician's portion. The forms must be submitted to our office a minimum of one week prior to the date of required submission. We cannot be responsible for forms given to the physician; they must be given to a back office assistant.
- There will be a \$25.00 charge for all missed appointments and a \$50.00 charge for all surgical appointments.

PATIENT SIGNATURE _____ Date _____

PARENT/GUARDIAN SIGNATURE _____ Date _____