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Patient General Information

Patient name: (*First, Middle, Last*) _____

Preferred name: (*optional*) _____

Date of Birth: (*mm/dd/yyyy*)_____ Sex: (*male/female/unidentified*) _____ SSN: _____

Marital Status: (*single/ married/ widowed/ separated/ divorced*) _____

Primary Address: _____ City: _____ State: ____ Zip: _____

Unit/Apt Number: _____ Cell: _____ Home: _____

E-Mail: _____

Would you like to receive voice, email, txt messages reminders and appointment updates from us? (Y/N) ____

Preferred contact method: (*Cell/ Home/ Work/ Email*) _____ May we leave a voice message with detailed information or results: (*Y/N*) ____ Okay to correspond through email with detailed information: (Y/N)____

Preferred Language: (*English/ Spanish/ Other*)_____

Employment Status: (*Employed/ Retired/ Unemployed*) _____ If "Employed", Occupation: _____

Race/Ethnicity: *(African American/Asian/Hispanic/Native American/White/Other*) _____

Primary physician: (N/A if none) _____ Referring physician: (N/A if none) _____

Emergency contact name: _____ Relationship: _____ Phone #: _____

Preferred pharmacy: _____ Major crossroads: _____

Pharmacy phone #: _____ Pharmacy Address: _____

How did you hear about us? _____

Primary Insurance Company: _____

Primary Insurance Policy holder: (*Self/Spouse/Child/Other*): _____

If **PRIMARY** *policy holder is* **NOT** *"Self", Holder Name*:_____ DOB: (*mm/dd/yyyy*)_____

Secondary Insurance Company: _____

Secondary Insurance Policy holder: (*Self/Spouse/Child/Other*): _____

If **SECONDARY** *policy holder is* **NOT** *"Self", Holder Name*:_____ DOB: (*mm/dd/yyyy*)_____

I AUTHORIZE TALUS INMOTION LLC TO: PERFORM DIAGNOSTIC PROCEDURES AND TREATMENTS AS MAY BE NECESSARY FOR PROPER MEDICAL CARE, RELEASE MY MEDICAL RECORDS TO ANY OTHER PHYSICIAN OR MEDICAL FACILITIES DIRECTLY INVOLVED IN MY CARE AND FOR THE PURPOSE OF ADMINISTERING CLAIMS AND TO OBTAIN MEDICATION HISTORY FOR THE PURPOSE OF TREATMENT, ASSIGN PAYMENT OF MY MEDICAL BENEFITS TO TALUS INMOTION. I HAVE BEEN MADE AWARE OF AND UNDERSTAND TALUS INMOTION'S: NOTICE OF PRIVACY PRACTICES, PATIENT OFFICE/FINANCIAL POLICY, AND DIRECT PAYMENT NOTICE. THE NOTICE TO PATIENTS DISCLOSES THAT TALUS INMOTION PROVIDERS HAVE DIRECT FINICAL INTEREST IN SEPARATE DIAGNOSTIC OR TREATMENT AGENCIES OR IN NONROUTINE GOODS OR SERVICES THAT THE PATIENT IS BEING PRESCRIBED AND THAT PRESCRIBED TREATMENTS, GOODS OR SERVICES ARE AVAILABLE ON A COMPETITIVE BASIS.

Patient/ Parent/ Guardian Signature: X_____ Today's Date: _____

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Review of Systems & Medical History

Patient name: (*First, Last*) _____ Occupation: _____

Height: ____ft ____in Weight: _____ Hand dominance: (Left/Right/Ambidextrous) _____

Any recent falls? :(Yes/No) _____ If "Yes", were you injured? : (Yes/No) _____

Did you have a flu vaccination in the last year? :(Yes/No) _____

Pneumonia vaccination? :(Yes/No) _____ If "Yes", when: _____

INJURY/ PAIN/ CONCERN – INFORMATION

Reason for visit: _____ When did the problem start/date of injury: _____

How did it happen? _____

What makes it better? _____

What makes it worse? _____

Pain Frequency: (*Rare/ Sometimes/ Always*): _____ Pain Scale: (pick a number 1-10):_____

Received previous treatment for this? :(Yes/No) ____ If "Yes", Provider: _____ Month/Year: _____

Have you had any of the following images or tests for this issue: X-RAY, CAT SCAN, MRI, EMG, LABS, ULTRASOUND?

If you had any of these please list **which type** and **where** the test was performed: _____

List any medications or supplements you are currently taking:		List any allergies you may have (medications, food, latex, iodine, nuts, ect) and the reaction to each:	
Medication/Supplement:	Dose:	Allergic To:	Reaction:

Family History: place an X next to M (Mother) and/or F (Father)

Diabetes ___ M ___ F Heart Disease ___ M ___ F Arthritis ___ M ___ F Cancer ___ M ___ F
Hypertension ___ M ___ F Bunions ___ M ___ F Other conditions_____

Father Living? (Yes/No) _____ Mother Living? (Yes/No) _____

Social History

Living arrangements:(*With Spouse/ Significant Other/ Alone/ Assisted Living/ With Children/ Decline*) _____

Tobacco use: (Yes/No) ____ *If "Yes" (how much, how many years, and do you plan to quit)* _____

Alcohol use: (Yes/No) ____ *If "Yes" (how much, how many years, and do you plan to quit)* _____

Illicit Drug use: (Yes/No) ____ *If "Yes" (how much, how many years, and do you plan to quit)* _____

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Surgeries/Procedures: **Year**

Please place an "X" only next to the symptoms that are affecting you <u>TODAY</u>

General	**Ear, Nose, Throat**	**Respiratory**	**Musculoskeletal**
___ Fever	___ Decreased Hearing	___ Shortness of Breath	___ Joint Pain
___ Chills	___ Sore Throat	___ Coughing	___ Cramps
___ Fatigue	**Psychological**	**Hematology**	___ Weakness
Eyes	___ Anxiety	___ Easy Bruising	___ Muscle Pain
___ Blurry Vision	___ Depression	___ Easy Bleeding	___ Foot Pain Right
___ Double Vision	**Cardiovascular**	___ Blood Clots	___ Foot Pain Left
___ Eye Pain	___ Chest Pain	**Gastroenterology**	___ Ankle Pain Right
___ Eye redness	___ Fainting	___ Heartburn	___ Ankle Pain Left
___ Watering	___ Murmurs	___ Nausea	___ Falling
Dermatology	___ Palpitations	___ Vomiting	**Neurology**
___ Redness	**Endocrinology**	___ Diarrhea	___ Numbness
___ Rash	___ Weight Change	**Vascular**	___ Tingling
___ Itching	___ Thirsty all the time	___ Swollen Legs	___ Loss of balance
___ Wounds	___ Excessive urination	___ Pain in calf/calves walking	___ History of seizure
___ Non-Healing Wounds		___ Pain in calf/calves sleeping	___ Tremors
___ Toenails Painful			___ Unsteady Gait

Please place an "X" only next to the symptoms that apply to you

___ Alcohol abuse	___ Depression	___ Hepatitis/ jaundice	___ Scoliosis
___ Alzheimer's	___ Diabetes type 1	___ Hiatal hernia	___ Seizure disorder
___ Anemia	___ Diabetes type 2	___ High cholesterol	___ Sickle cell
___ Aneurysm	___ Dialysis	___ HIV/AIDS	___ Sleep apnea w/CPAP
___ Anxiety	___ Diverticulitis	___ Kidney disease	___ Sleep apnea w/out CPAP
___ Arthritis	___ Drug abuse	___ Kidney stones	___ STD/STI
___ Asthma	___ Eczema	___ Leukemia	___ Stomach disease/ ulcer
___ Back pain	___ Emphysema	___ Liver disease	___ Stroke
___ Bipolar	___ End State Renal Disease	___ Lymphedema	___ Swollen legs
___ Bladder disease	___ Epilepsy/ seizures	___ Migraine headaches	___ Thyroid disease
___ Blood clots/ DVT	___ Esophageal reflux	___ MRSA	___ TIA
___ Blood pressure – HIGH	___ Fibromyalgia	___ Multiple sclerosis	___ Tuberculosis
___ Blood pressure – LOW	___ Foot ulcer/wounds	___ Neuropathy	___ Valley fever
___ Bronchitis	___ Fracture/ broken bone	___ Osteoarthritis	___ Vascular disease
___ Cancer: (Type) _____	___ Gastric ulcers	___ Osteoporosis	___ Venous insufficiency
___ Cellulitis	___ Glaucoma	___ Pancreatitis	___ Wound healing
___ Cerebral palsy	___ Gout	___ Pneumonia	___ Other: _____
___ Chronic pain	___ Hay fever	___ Prostate disorder	_____
___ Congestive heart failure	___ Heart attack	___ Psychiatric illness	
___ COPD	___ Heart disease	___ Pulmonary embolism	
___ Dementia	___ Heart valve disease	___ Rheumatoid arthritis	

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Office/Financial Policies

Effective January 1, 2021

Thank you for choosing Talus InMotion Foot & Ankle (TIMFA) as your medical provider. Please carefully read and sign below. This policy has been put into place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our staff will be glad to discuss these policies with you.

I understand that if I do not have my insurance card, referral/prior authorization and/ or co-payments the day of my appointment, that my appointment may be rescheduled until such a time that I can provide documents or payments.

I understand that TIMFA will collect, prior to any office visit and procedure, deductible and coinsurance up to an amount equal to payment in full for the planned office visit. Payment in full and expected coinsurance payment responsibility are determined by the anticipated medical billing code(s), details of your insurance policy and agreement between your insurance company, and Talus InMotion Foot & Ankle. It is recommended that you call your insurance company to verify your coverage. If full deductible is not applied to your claim by your insurance company, we will refund any overpayment to you within 30 days of the date we received the overpayment.

TIMFA will allow 60 days from the date of filing for my insurance company to process or pay a claim. Arizona law allows insurance companies operating in the state, no more than 30 days to process claims. It is my responsibility to notify TIMFA if there are any changes in my insurance coverage, residence or phone number. Ultimately, it is up to me to know my insurance benefits.

I understand that Co-pays are due on the Date of Service. An additional, non-refundable, $10.00 surcharge will be added to my co-pay if I am unable to pay prior to my visit. I understand that the $10.00 surcharge will be waived if a payment is called into the office by 5pm, the same business day.

I understand that if my account is not paid in full within 90 days, a $20.00 collection processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

I understand that I may be charged $100 fee for any missed appointments not canceled within at least 24-hour advanced notice. I also understand that if I am 10 minuets late for my appointment that I may be charged a $25 late fee and may be asked to reschedule my appointment.

I understand that a $75 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's checks, money order or cash).

Documentation/Prior Authorization Fee: There will be a $12 or more fee for all documents/letters that need to be completed by the provider. The fee will be determined by the complexity of the document requested. There will be an annual $35 fee for all prior authorizations needed for treatment (Prescriptions, DME, etc.) at TIMFA.

Medical Records Fee: There will be a $25 plus .25cents per page fee for patients requesting a copy of their personal records and $5.00 for a CD copy of X-rays. Medical records will be sent to another provider at no charge.

Surgical Fee: I understand prior to my surgery date I will be responsible for a deposit of $500.00, depending on my insurance deductible and/or coinsurance. I also understand that if I am unable to keep my scheduled surgery, I must contact TIMFA at least two business days prior to my scheduled surgery date or a $250.00 fee will be assessed.

Custom Orthotics: I understand that TIMFA may bill my insurance companies for custom foot orthotics. However, my cost maybe up to $550.00. A $275.00 deposit is due at the time of casting.

Minor Age Patients: TIMFA requires that a parent or legal guardian accompany all minor patients. The parent and or legal guardian that accompanies the minor for medical services will be responsible for payment.

Release of Information: I authorize TIMFA to release any information acquired in the course of my treatment as required for processing insurance claims. I also authorize the release of medical information to any requesting source presenting a signed authorization by me. I understand TIMFA participated in an organization health care arrangement consisting of greater Phoenix metropolitan area hospitals as well as physicians who have medical staff privileges at one or more of these hospitals. Participants in this arrangement work together to improve the quality and efficiency of the delivery of healthcare to their patients. As a participant in this arrangement, TIMFA may share your PHI with other members of this arrangement for purposes of treatment, payment or the healthcare operations of this organization health care arrangement.

Authorization to Treat: I hereby authorize the staff of TIMFA to provide me with medical treatment. I agree to inform the if I have concerns about my medical treatment at the time the services are being rendered

I have read and understand the above Office/Financial policy and I agree to abide to its terms.

_____	_X_____	_____
Printed Name of Patient	Signature of Patient/Responsible Party	Today's Date

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Direct Payment Notification

The Arizona State Constitution permits you to pay a healthcare provider directly for health care services. Before you make any agreement to do so please read the following important information.

If Talus InMotion Foot & Ankle is contracted with your insurance, the following guidelines apply:

1. You may not be required to pay TIMFA directly for the services covered by your plan, except for cost-share amounts that you are obligated to pay under your plan, such as copayments, coinsurance and deductible amounts. Non-covered services include but not limited to PalinGen Flow (amnio), PRP, Shockwave, Custom Foot Orthotics, Prefabricated Orthotics, Laser Therapy and Fungal Toenail Laser Therapy.
2. TIMFA agreement with your insurance may prevent TIMFA from billing you for the difference between TIMFA billed charges and the amount allowed by your health plan for covered services.
3. If you pay directly for a health care service, TIMFA is not responsible for submitting claim documentation to your insurance. Before paying your claim, your health plan may require you to provide information and submit documentation necessary to determine whether the services are covered under your health plan.
4. If you do not pay directly for a health care service, TIMFA may be responsible for submitting claim documentation to your health plan for the healthcare services.

Your signature below acknowledges that you received this notice before paying TIMFA directly for a healthcare service.

_____ _____ _____

Printed Name of Patient | Signature of Patient/Responsible Party | Today's Date

Acknowledgment of Receipt of Notice of Privacy Practices

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

_____

Initial/Responsible Party Today's Date

Appointment Reminder Utilization

I authorize TIMFA to send appointment reminders electronically via text message, voice message or email. I understand this is a free service and that text messaging rates from my mobile carrier may apply.

_____

Initial/Responsible Party Today's Date

Prescription Verification

I authorize TIMFA to obtain my medication history from my pharmacy my health plans, and my other healthcare providers. This collection of data is stored in the practice electronic medical records system and is held securely.

_____

Initial/Responsible Party Today's Date

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American Heart Association Pad Survey

Answers to the following questions will help determine if you are at risk for Peripheral Arterial Disease (PAD) and if a vascular examination can help better assess your vascular health status. Please answer Yes or No to all the following questions in the box indicated below.

Questions	Yes or No
Do you experience any pain in your legs or feet while at rest?	
Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hip or thigh during walking/exercise?	
If yes to Question 2, does the pain go away when you stop walking/exercising?	
Do your feet get pale, discolored or bluish at any time during the day?	
Do you have an infection, skin wound or ulcer on your leg or foot that is slow to heal over the past 8-12 weeks?	
Do you have high cholesterol or other blood lipid (fat) problems or require cholesterol medication?	
Do you have high blood pressure or take medication to reduce blood pressure?	
Do you have diabetes?	
Do you have a history of chronic kidney disease?	
Do you currently or have you ever smoked?	
Do you have a history of stroke or mini-stroke (TIA)?	
Do you have a history of heart disease (heart attack, MI)?	
Do you have a history of carotid stenosis, AA (abdominal aortic aneurysm), and/or stent placement?	

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Medical Records: Release of Information

I, _____Date of Birth: _____ give permission to
(Name of Patient)

Talus inMotion to disclose medical information to _____
(Name of Authorized Party)

Relation to Authorized party: _____

I agree that the above named person may also:

_____ Receive results
(initials)

_____ Make/change appointments
(initials)

_____ Pick up documents
(initials)

I understand that a record of this consent will be kept in my file and can only be retracted with written consent stating otherwise.

Patient Signature: X_____ Date: _____

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