Apache Foot & Ankle Specialists

4840 S. Fort Apache Rd. # 101
Las Vegas, NV 89147
Phone: (702) 362-2622
Fax: (702) 362-0422

2980 St. Rose Parkway Ste. 140
Henderson, NV 89052
Phone: 702-722-6633
Fax: 702-722-6634

TTY/TDD 800-969-6853

NOTICE TO OUR PATIENTS

Although we participate with most insurance plans, **you as the patient and/or insured party are responsible for co-pays, deductibles and any non-covered services, which are outlined, in your insurance benefit plan.**

This also applies to any hospital outpatient services such as surgery, testing and labwork.

We will try to notify you of your benefits at the time of service, but there are always exceptions, which may not be known until the bill is submitted to your insurance company. If you have specific concerns, please let us know and we will attempt to assist you or you may contact your insurance company directly with any questions.

With your signature you are excepting responsibility for your medical expenses as outlined in your insurance benefit plan.

_____ _____

PATIENT/INSURED SIGNATURE **DATE**

INSURANCE COMPANY:_____ **OFFICE VISITS PAYABLE Y N**

Office Visit Co-pay: _____

Procedure Co-pay: _____

Deductible: _____

**PAYMENT OF CO-PAYS AND ANY OUTSTANDING BALANCES ARE EXPECTED AT TIME OF SERVICE UNLESS OTHERWISE NOTED*

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PATIENT INFORMATION

Patient's last name: First: Middle Int:

Birth date: Age: Sex: M F Marital Status: Single / Mar/ Div / Wid

Street Address: City State Zip Code

Phone Number: ( ) Cellular Number: ( ) Work Number: ( )

Social Security Number (**Not Optional**) __ Self __Other, please Specify full name: _____
(If under 18, Parent or legal guardian SSN#)_____

Email Address:
_____

Occupation Employer Address

How were you referred to us?

INSURANCE NFORMATION

Primary Insurance
Subscriber's Name: ID Number: Group Number:

Date of Birth Phone Number Mailing Address

Secondary Insurance
Subscriber's Name: ID Number: Group Number:

Date of Birth Phone Number Mailing Address

IN CASE OF EMERGENCY

Name of Local Friend or relative (Not living in the same address) Home Phone Work Phone

Address

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Apache Foot & Ankle Specialists or insurance company to release any information required to process my claims.

_____ _____

Patient Signature Date
(If patient is under 18, Parent or legal guardian signature)

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PATIENT HISTORY

Patient Name: _____DOB:_____

Medication Allergies: _____ Reaction:_____

Other Allergies:_____ Reaction:_____

PLEASE MAKE AN (X) BY ANY OF THESE CONDITIONS YOU MAY HAVE OR HAVE HAD IN THE PAST:

___Heart Disease	___Liver Disease	___ Lumbar Spine Disorder
___High Blood Pressure	___Bowel Disease	___Severe Headaches
___High Cholesterol	___Cancer (past or present)	___Tuberculosis/TB
___Lung Disease	___Anemia	___Muscle Disease
___Diabetes	___Blood Clots	___Mental Health Problems
___Hypoglycemia (low glucose)	___Bleeding Tendency	___Depression
___Thyroid Disease	___Stroke	___Chronic Skin Disease
___Stomach Disease	___Seizures	___Sleep Apnea
___Nerve Impairment	___Kidney, Bladder, or Prostate Disease	___Other_____
___Joint Replacement	___Cervical Spine Disorder	

CURRENT MEDICATIONS (include non-prescription products)

1)_____ MG_____ How often_____	7)_____ MG_____ How often_____
2) _____ MG_____ How often_____	8)_____ MG_____ How often_____
3) _____ MG_____ How often_____	9)_____ MG_____ How often_____
4) _____ MG_____ How often_____	10)_____ MG_____ How often_____
5) _____ MG_____ How often_____	11)_____ MG_____ How often_____
6) _____ MG_____ How often_____	12)_____ MG_____ How often_____

PERSONAL HABITS

Do you drink caffeinated beverages (coffee, tea, soda)? ____ Daily intake? ____ Years of use: _____

Do you drink alcoholic beverages?____ If yes, ___ drinks ( ), ( )week, ( )month. Years of use:____

Do you smoke or chew tobacco?____ If yes,___/day. Years of use :_____. If no, any prior nicotine use? ___ Years of use:___

MAJOR SURGERIES

Approximate Date: _____ Surgery:_____

Approximate Date: _____ Surgery:_____

Approximate Date: _____ Surgery:_____

Approximate Date: _____ Surgery:_____

WHAT PROBLEM(S) ARE YOU BEING SEEN FOR TODAY?

_____

_____

_____

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PATIENT RESPONSIBILITY

1: Payment of deductibles, co-pays, co-ins, or cash services is expected at time of service. We accept Cash, Credit, and Care Credit. Those left unpaid will be sent to collections, and you will be responsible for the fee's accumulated from our collection company.

2: Twenty-four (24) hour notice is required for cancellation of all appointments. Failure to cancel an appointment within this time frame or failure to show for a scheduled appointment will result is a **$50.00** charge being added to your account.

3: There will be a fee of **$25.00** for all Paperwork that needs to be filled out by the doctor. This includes any forms given by your Employers, Insurance Company, and/or disability insurance.

4: Having insurance is **NO** guarantee that services rendered will be paid for by your insurance. You will be billed for denied/non-covered/or unpaid services. It is ultimately the patient's responsibility to understand his/her insurance coverage and/or plans.

5: It is **YOUR** responsibility to know what doctors or facilities are covered by your insurance policy. You will be expected to pay any services not covered by your insurance.

6: Copies of all valid insurance cards are required in order for us to bill your insurance. If you do not have this at the time of your visit you may be requested to reschedule the visit until such time as you can provide proof of insurance coverage, or you may be asked to pay for your visit in full at the time of service.

7: If your insurance requires a referral from your PCP to see a specialist, it is **YOUR** responsibility to obtain this and provide our office with a copy. If you do not have a copy of your referral you may be asked to reschedule your visit until the referral is obtained or you may be asked to pay for services in full prior to seeing the doctor.

8: If your insurance company denied your claim because they need additional information from you or another one of your providers, it is **YOUR** responsibility to make sure your insurance company receives this information. If you do not provide this information to your insurance company and your claim remains denied, you will be expected to pay for these services.

9: Request for any/all medical records will be charged at $.60 cents a page and $3.00 for all X-ray images.

OTHER PATIENT RESPONSIBILITY

Photo I.D. required this our way of making sure we are treating the correct patient. If the patient is a minor we will require photo I.D. of a parent/guardian. If you cannot provide this information, we will need to reschedule your appointment.

Patient Name: _____ Date: _____

Patient Signature: _____
(If patient is under 18, Parent or legal guardian to sign above)

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BILLING POLICY

ALL Office Visit Co-pays are due at time of service.

BALANCES UNDER $100.00

ALL Balances incurred **UNDER $100.00** must be paid in **FULL** within **30 days of billing statement date**. There will be a $25.00 rebilling charge every time an additional statement is issued for the original charge.

BALANCES OVER $100.00

ALL balances incurred **OVER $100.00** must be paid within **90 days** of **original statement date**. The arrangements of payment is as follows:

30% of balance is due at 30 days
30% of balance is due at 60 days
Remaining balance due at 90 days

PATIENT FINANCIAL RESPONSIBILITY STATEMENT:

You are responsible for payment of any and all copayments at the time of services rendered. Payment for any deductible and co-insurance, as determined by your contract with your insurance carrier, must be paid in full as stated in the above office policy. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurance carrier. If your insurance carrier denies any part of your medical claim submitted, you will be responsible for your account balance in full. It is the insured's responsibility to know the coverage and out of pocket costs of his or her's medical coverage plan.

I have read the above policy, regarding my financial responsibility to **APACHE FOOT & ANKLE SPECIALISTS PLLC**, for providing services to the below named patient or me. I certify, that the information provided by the below named patient or me, with regards to effective insurance policy, billing address and phone number, is to the best of my knowledge true and accurate. I authorize my insurer to pay any medical benefits on my behalf to **APACHE FOOT & ANKLE SPECIALISTS PLLC**. I agree to pay **APACHE FOOT & ANKLE SPECIALISTS PLLC** the full and entire amount of any and all medical bills incurred by me or the below named patient, and, if applicable, any amount due after payment has been made by my insurance carrier, including any and all fees associated with collection services needed as a result of non-payment.

Signature _____(relationship to patient: **SELF GUARDIAN OTHER**_____)

PATIENT NAME (printed):_____ _____DATE: _____

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Pharmacy Information

Pharmacy_____
Address_____
City _____ State _____ Zip code _____
Phone Number_____ Fax Number _____
Cross Streets_____

Medical Release Authorization

I, _____, hereby authorize Apache Foot and Ankle Specialists to release my records to:

1. _____
2. _____
3. _____
4. _____
5. _____

_____ _____ _____
Patient Signature Date of Birth Date

PATIENT CONSENT

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Patient Name: _____

PATIENT CONSENT:
I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain information from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Patient Signature: _____ Date:_____
(If patient is under 18, Parent or legal guardian to sign above)

CONSENT TO TREATMENT:
I, the patient, parent, guardian, or guarantor, consent to treatment for the above named patient by the physician, Lee A. Wittenberg, DPM and/or Christina Hulsebos, DPM. I consent to the release of protected health information in order that Lee A. Wittenberg, DPM and/or Christina hulsebos DPM, can conduct, plan and directly treatment, obtain from third party payers, and conduct normal healthcare operations. I understand that no further release of protected health information will be allowed unless I sign an authorization to release medical information.
Release of protected information for normal healthcare operations includes providing such information to your insurance company in order to obtain payment or authorization for services, verify coverage and benefits, and/or providing information to other providers in your treatment or care. Information is released on a need to know basis.

Patient Signature: _____ Date:_____
(If patient is under 18, Parent or legal guardian to sign above)

CONSENT TO BILL INSURANCE:
I authorize the filing of any insurance claims on the patient's behalf and sign payment to Lee A. Wittenberg, DPM and/or Christina Hulsebos, DPM. I understand that I am liable for payments of any charges incurred regardless of insurance coverage.

Patient Signature: _____Date:_____
(If patient is under 18, Parent or legal guardian to sign above)

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COMPLIANCE NOTIFICATION FOR OUR PATIENTS

To our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors, continuously undergo training so that they may understand and comply with government rules and regulation regarding the HIPAA with particular emphasis on the "Privacy Rules". We strive to achieve the very highest standards of the ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate users of PHI in accordance with the government rules, laws, and regulation. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of the fact, our policy is to listen to our employees, and our patients without any thought of penalization if they feel that an event in any way compromises our policy integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for your time and consideration. If you have questions, please feel free to call the number above.

THIS COPY IS FOR YOU TO KEEP