

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 accepting 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:

Marital Status:

M F

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 INFORMATION

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

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

Date

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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:

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Lumbar Spine Disorder |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bowel Disease | <input type="checkbox"/> Severe Headaches |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Cancer (past or present) | <input type="checkbox"/> Tuberculosis/TB |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Muscle Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Mental Health Problems |
| <input type="checkbox"/> Hypoglycemia (low glucose) | <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Chronic Skin Disease |
| <input type="checkbox"/> Stomach Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Nerve Impairment | <input type="checkbox"/> Kidney, Bladder, or Prostate Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> 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 in 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

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Patient Name: _____

PATIENT CONSENT:

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 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(s) at Apache Foot and Ankle Specialists, PLLC. I consent to the release of protected health information in order that the physicians, 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 Apache Foot and Ankle Specialists, PLLC. 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