FOOT & ANKLE SPECIALISTS
PATIENT DEMOGRAPHIC SHEET

2705 Samson Way **Bellevue NE 68123**
1301 N 72nd St **Omaha NE 68114**
18010 R Plaza, Suite 106 **Omaha NE 68135**

☐ **Chad A Summy, DPM** ☐ **Shannon M Lensing DPM**
☐ **Michelle L Hinze, DPM** ☐ **Donald E Buddecke, DPM**

Patient's First Name:		**Middle Initial:**		**Patient's Last Name:**	
Patient's Social Security#		**Patient's Date of Birth**		**Gender**	☐ **Male** ☐ **Female**
Home Address					
City		**State**		**Zip+4**	
Mailing Address:	(**if different from Home Address**)				
City		**State**		**Zip+4**	
Phone: Home		**Preferred Phone Contact:** ☐ **Home** ☐ **Cellular** ☐ **Work**			
Phone: Cellular		**Preferred Communication Contact (For appointment reminders, lab results, etc.)** **Phone: (** ☐ **Home** ☐ **Cellular** ☐ **Work)** ☐ **Email** ☐ **Mail**			
Phone: Work					
Email Address					
Emergency Contact Person	**Name**				
	Phone#		**Relationship**		

Please Circle Related Box				**Please Circle Related Box**		**Please Circle Related Box**	
Racial Category				**Ethnicity**		**Preferred Language**	
	African American		American Indian/Alaska Native		Hispanic/Latino		English
	Asian		Hispanic		Not Hispanic/Latino		Spanish
	Native Hawaiian		More Than One Race		Choose Not To Tell		Choose Not To Tell
	White/Not Hispanic		Choose NotToTell				Other:

Marital Status:	☐ **Single** ☐ **Married** ☐ **Other**
Job Description	
Employer/Address:	
Primary Physician Name:	
Primary Physician Address:	
Preferred Pharmacy	
Preferred Pharmacy Address	
Please check & Initial both lines.	Consent given for our office to share information regarding your exam and treatment to patient's medical care provider(s) (ex: Primary care doctor) ☐ **I consent** ☐ **I do not consent** _____ **Initial**
	Consent given to access patient external prescription history. ☐ **I consent** ☐ **I do not consent** _____ **Initial**

Insurance Policy Holder Information (if different from Patient)		**For The:** ☐ **Primary** ☐ **Secondary**
First Name		
Last Name		
Policy Holders' Address (if different from Patient's)		
Policy Holders' Social Security#	**Date of Birth:**	
Patient's Relationship to Policy Holder:	☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**	

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT IT IS AS A COURTESY THAT THE DOCTOR ACCEPTS MY INSURANCE FOR PAYMENT AND THAT IF FOR ANY REASON, THEY DO NOT PAY MY BILL THAT I AM RESPONSIBLE.

Patient and/or Guardian Signature: _____ **Date:** _____

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*NICOLE WEINHOLD, PT * TESSA JANSEN, PT
Phone: (402) 991-8999 Fax: (402) 331-6537

Consent for Sharing of Protected Health Data and Information

This form does not authorize the release of medical records

1. Please list the names and relationship of family members or other persons, if any, whom we may inform verbally about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

1. _____ Name/relationship
2. _____ Name/relationship
3. _____ Name/relationship
4. _____ Name/relationship

2. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home address.

_____

_____

3. Please print the telephone numbers where you want to receive calls about your appointments, lab and test results, or other health care information.

- HOME _____
- WORK _____
- CELL PHONE* _____
- OTHER PHONE _____

* I am fully aware that a cell phone is not a secure and private line

4. Can confidential messages (i.e. appointment reminders, test results, etc.) be on your telephone answering machine or voicemail?
YES_____ NO_____

PATIENT NAME_____
CHART NUMBER_____ AGE IF MINOR_____

X_____ Date of signing_____
Signature of Patient

X_____ Date of signing_____
Signature of Patient's Representative/Guardian

_____X_____
Representative's Relationship to Patient Witness Signature (Office Representative)

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Foot & Ankle Specialists
2705 Samson Way
Bellevue, NE 68123
(402) 331-6387

I understand that, under the Health Insurance Portability & 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 payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name_____

Relationship to Patient:_____

Signature:_____

Date_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason: _____

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Financial Policy

2705 Samson Way, Bellevue, NE 68123 18010 R Plaza, Suite #106, Omaha, NE 68135
1301 N. 72nd Street, Omaha, NE 68114

Thank you for choosing us as your podiatric health care provider. This is an agreement between the providers of Foot and Ankle Specialists, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we", "us", and "our" refer to the Providers of Foot and Ankle Specialists.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately all remainder balances on charges, if any, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Payment options if you have no insurance:

1. You choose to pay by cash, check or credit card on the day that treatment is rendered.
2. On treatment involving laboratory fees you may choose to pay 50% on the preparation date and the balance in three weeks.
3. On extensive treatment, you may prefer to secure a bank, credit union, or third party financing for the entire amount and make payments to the lending institution.

Payment options if you have insurance:

1. Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.
2. You choose to pay your deductible and any out-of-pocket portions at the time services are rendered by cash, check or credit card.
3. For established patients with balances on accounts under $100, payment is expected in full at time of service.

Appointment Cancellation: If it is necessary to cancel you scheduled appointment we require that you call by 10 a.m. one (1) working day in advance. Appointments are in high demands and your early cancellation will give another person the possibility to have access to timely medical care.

No Show Policy: A "No Show" is someone who misses an appointment without canceling it. A failure to present at the time of a scheduled appointment will be recorded in your chart as a 'No Show". An administrative fee of $20.00 for "no shows" will be billed to the patient account. The patient will be sent a letter alerting them to the fact that they have failed to show up for an appointment and did not cancel within the requested time frame in advance. A copy of the letter will be placed in the patient's file. Three (3) "no shows" will result in the temporary suspension of services. The patient may not be reschedule for future appointments at Foot and Ankle Specialists and will be asked to leave the practice

The Financial Policy continues on the back side of this page.

I have read and understand the Financial Policy of Foot and Ankle Specialists and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice

Patient Name: _____

Signature: _____ **Date**: _____

Responsible Party: _____
(If patient is a minor)

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Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are **NOT a party to this contract.** We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company

Divorce: In case of divorce or separation, the party responsible for the account prior to divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part or the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Douglas County, Nebraska.

Returned Checks: There is a fee (currently $**25**) for any checks returned by the bank.

Re-billing Fee: A re-billing fee of $**5** will be imposed on each account that is over sixty (60) days past-due. We determine your account is past-due by taking the balance owed sixty (60) days ago, and then subtracting any payments or credits applied to the account during that time.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Transferring of Records: You will need to request in writing if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to personal injury case.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

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General Patient Consent for Care

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Foot and Ankle Specialists on an outpatient/ office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary. I agree and acknowledge that Foot and Ankle Specialists is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Foot and Ankle Specialists. facilities.

Telemedicine

I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care.

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video

Patient Name_(print)_____date_____

Signed Consent of Patient_____

I hereby give my consent to treat minor child/children below, which is under the legal age of nineteen years of age

Patient Name_____Patient Age _____

Signed consent of parent guardian_____