FOOT & ANKLE CENTER OF OKLAHOMA

Dr. Darren Elenburg, DPM, FACFAS
Dr. Bryce Corlee, DPM, FACFAS

Name:_____ **Date of Birth:**_____ **SSN:**_____
(Last) (First) (MI)

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

Home Phone (_____) _____-_____ **Cell Phone (_____) _____-_____** **Marital Status:** S M W D

Email Address:_____ **Preferred Method of Contact:** Phone Email Mail Text

Occupation:_____ **Patient Employer:**_____

Employer Phone: (_____) _____-_____ **Employer Address:**_____

Emergency Contact:_____ **Relationship:**_____**Phone (_____)_____-_____**
(First) (Last)

Primary Language:_____ **Circle Ethnicity:** Hispanic Non-Hispanic

Circle Race: Declined Black or African American American Indian or Alaska Native
White Native Hawaiian or Other Pacific Islander Asian

Primary Care Doctor:_____ **Phone (_____) _____-_____**

Are You Diabetic? Yes No If ***YES***, Please Provide the Following:

Diabetes Doctor:_____ **Phone (_____) _____-_____**

Date of your last appointment with them (for your diabetes):_____

How did you hear about our office? Family Friend Advertisement Dr. Referral:_____

For Parents of Minor Children:

We must have an ID for the parent/guardian that brings the child to his/her appointment. In addition, we need the complete address, phone number and date of birth for the primary insurance holder. If we do not have this information, your insurance company will deny your claim. Please complete the section below, and thank you in advance for your cooperation.

Insured Name:_____ **Insured Date of Birth:**_____ **Insured SSN:**_____

Insured Employer:_____ **Employer Phone (_____) _____-_____**

Person Responsible for Bill:_____ **Phone (_____) _____-_____**

Address:_____

Personal Representative Authorization for Medical Release Form

609 W Memorial Road
Oklahoma City, OK 73114
405-418-2676
405-418-2677 Fax

Patient:..... **Date of Birth:**.....

I authorize The Foot and Ankle Center of Oklahoma to speak to the following person(s) regarding:

- **All medical information,** including but not limited to, records pertaining to examinations, treatments, consultants, billing records, x-rays and reports, history, laboratory findings, admission and discharge reports, treatment records, diagnosis and prognosis records, nurse's and doctor's notes, and any other non-medical information in my chart.
- **Only the following types of information:**

  _____

  _____

  _____
- **I want no one to have access to my medical information.**

The above information listed shall only be released to the following person(s):

Name of Authorized Person(s)	Relationship	DOB	Phone Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I understand that I may terminate this Medical Authorization form at any time. I must notify The Foot and Ankle Center of Oklahoma in writing regarding the termination and effective date.

Signature_____ **Date**_____

List of Medical History

Patient Name:_____

Have You EVER Had Any Of The Following Medical Problems? [CHECK YES OR NO]

	YES	NO		YES	NO
ANEMIA			GERD		
ARTHRITIS			GOUT		
BACK PROBLEM			HIV		
CORONARY ARTERY DISEASE			HEPATITIS **TYPE:**_____		
CONGESTIVE HEART FAILURE			HISTORY OF FOOT WOUNDS		
COPD			HYPERTENSION		
CANCER **TYPE:**_____			HEART ATTACK		
ELEVATED CHOLESTEROL			STROKE		
DEMENTIA			THYROID DISEASE		
DEPRESSION			STOMACH ULCER		
DERMATITIS			HISTORY OF DVT:		
DIABETES **LAST A1C:**_____			OTHER:		
EPILEPSY			OTHER:		

SHOE SIZE:_____ **HEIGHT:**_____ **WEIGHT:**_____

Patient Name:_____

Please list your CURRENT medications

MEDICATION	DOSAGE	MEDICATION	DOSAGE

PRIMARY PHARMACY:_____ **PHONE (_____) _____-_____**

ADDRESS (IF UNKNOWN, PLEASE LIST CLOSEST CROSS STREET):_____

Please List ANY Allergies That You Have:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Surgical History:

PROCEDURE:_____ **SURGEON:**_____**DATE:**_____

PROCEDURE:_____ **SURGEON:**_____**DATE:**_____

PROCEDURE:_____ **SURGEON:**_____**DATE:**_____

PROCEDURE:_____ **SURGEON:**_____**DATE:**_____

Patient Name:_____

Have You Ever Had Any Issues With Anesthesia? [CIRCLE] YES NO

If 'YES', Please Explain:_____

Family History:

Mother:_____

Father:_____

Did You Receive Your Flu Shot This Year? _____ **YES** _____**NO** _____**I DO NOT GET THE FLU SHOT**

Do You Currently Use Tobacco Products? _____ **YES** _____**NO** _____**FORMER SMOKER**

If 'YES', How Often? _____**EVERYDAY** _____**SOME DAYS**

Do You Experience Pain In Your Calf Muscles When:

Walking? _____**YES** _____**No** **Resting?** _____**YES** _____**NO**

If 'YES', Have You Ever Had Circulation Testing Done On Your Legs? (Ultrasounds, Arterial Dopplers, etc.)

When?_____

Where?_____

What Are You Being Seen For Today?

_____

_____

_____

Was This Condition Caused By A Specific Injury? _____ **YES** _____**NO**

IF 'YES', WAS IT FROM _____**AUTO ACCIDENT** _____**WORK INJURY** _____**OTHER:**

_____

_____

Patient Name:_____

How Long Has The Problem Been Bothering You?

_____

Please List Any Treatments You Have Tried For This Condition (BY YOU OR A DOCTOR):

_____

_____

_____

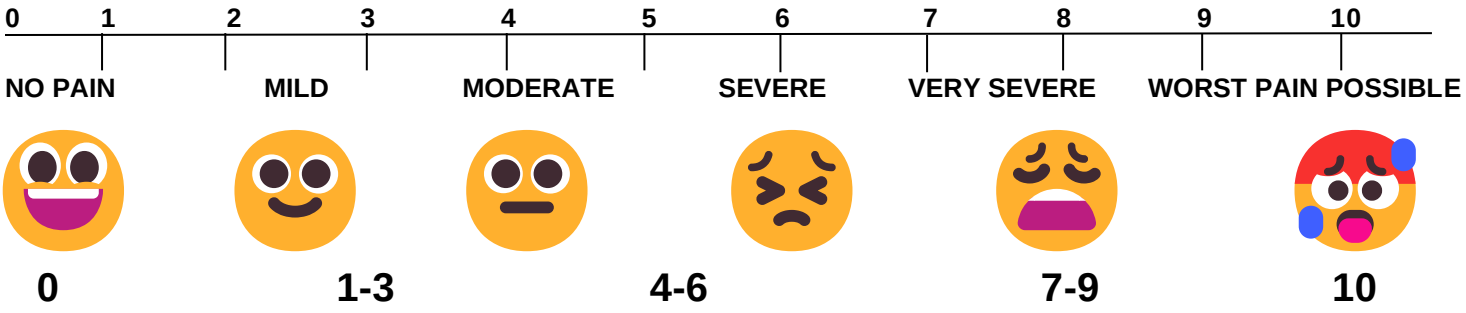
Have You Had Any X-Rays Or Other Advanced Imaging Done For This Problem? _____YES _____NO If 'yes', Please List When And Where:

_____

_____

_____

Using The Scale Below, Please Indicate Your Level Of Pain: [CIRCLE RANGE]



Financial Policy

Thank you for choosing us as your Foot & Ankle Specialist. We aim to provide you with the highest quality of care at the most reasonable prices. We invite you to discuss with us any questions you have regarding our services or payment policies. The best health services are based on mutual understanding between provider and patient.

Please be prepared to pay any co-pay, non-covered, and/or over-the-counter charges at the time of your visit.

For the purpose of payment, I allow Foot & Ankle Center of Oklahoma to release my Private Health Information to any and all of my insurance carriers, their third-party payers, and claim reviewers until the claim is resolved. For the purpose of treatment, I also allow the above-listed practice to release my information or contact any and all of my treating physicians.

Minor Children: Parents or guardians of minor children are responsible for financial obligations incurred for medical services received. In the case of divorced parents, the parent bringing the child to his/her appointment is responsible for any balance incurred. As a courtesy, we are happy to file your claim with insurance; however, final payment is the parent/guardian's responsibility.

Insurance: Your insurance policy is a contract between you, your employer, and your insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. It is your responsibility to know your benefits, as they vary depending on your particular contract. It is also your responsibility to provide any referrals or authorizations that may be required by your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY, WHETHER YOUR INSURANCE PAYS OR NOT.**

Co-payments, Deductibles, and Co-Insurance: All co-pays and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-pays and deductibles from patients can be considered fraud. The Foot & Ankle Center of Oklahoma is not a bank or financial institution. We do not extend credit or carry balances on accounts. We accept cash, check, MasterCard, Visa, Discover, American Express, and Care Credit. Care Credit financing requires advance pre-authorization, and these arrangements must be made with the office staff before your appointment.

Proof of Insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your Driver's License/ID and current valid insurance card to provide proof of insurance.

Durable Medical Equipment / Non-Covered Services: Many insurance companies do not cover Durable Medical Equipment (DME). We often use these items for your appropriate care, and you may be responsible for these purchases. Items commonly used include but are not limited to Custom Orthotics, pre-made orthotics, surgical shoes, removable casts, braces, and bandages. You are responsible for any non-covered services you choose to receive. You will be informed of any non-covered charges and must

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pay for them in full before leaving our office. Non-covered items will not be billed to your insurance. In the case of custom items, it is our policy to dispense them in the office to ensure that the items fit the patient. When the item is received in our office, we will contact you and schedule a fitting. If, after 30 days, we cannot contact you, we will ship the item to your home address. We will bill your insurance for the appropriate charges, and you will be responsible for the shipping costs incurred.

Missed Appointments: Our policy is to charge $30, plus any additional costs incurred by our office on behalf of the patient, for a missed appointment if not canceled within 48 hours. This charge is at our discretion. Please help us serve you better by keeping your regularly scheduled appointment.

Deposit for Surgery: If you are planning to have surgery, we require a refundable $500 deposit due by the Wednesday prior to your surgery. This is refundable only after insurance has paid for the surgery.

Cancellation of Surgery: If you cancel your surgery within 3 days or less of the scheduled time, our policy is to charge $100 plus any additional costs incurred by our office on behalf of the patient. This charge is at our discretion.

Non-Payment: After 90 days of non-payment, you will receive a 10-day collection notice from our billing office. If there is no response within the allotted time, your account will be turned over for collections and be subject to a 30% collection fee. All collection fees, legal fees, and court costs will be added to the patient balance and the balance due to the office.

NSF Checks: Restitution for returned checks is required within 7 working days with cash, money order, or credit card, and will be subject to a $25 returned check fee. If checks are not picked up within the allotted time, they will be turned over to the District Attorney for prosecution.

Forms and Documents: Completion of ALL forms, such as disability applications, FMLA paperwork, etc., will be subject to a $25 fee. Please allow 72 hours for a request for records from our office.

Medicare Patients: Please understand that taking ASSIGNMENT means that YOU are responsible for the yearly deductible and the 20% co-insurance of what Medicare allows. If your secondary insurance carrier does not cover co-pays/co-insurance, you are responsible for the balance.

I understand that honest and complete answers to each question on the previous pages are important to my medical care. I answered them to the best of my ability. I have been informed that if I am uncertain about any question(s) on these forms, I should ask the doctor or a member of the office staff for assistance.

I have read, understood, and received a copy of the payment policy, and I agree to abide by its guidelines.

Patient signature_____**Date**_____