Eulano Foot & Ankle
4921 E BELL RD., #205
SCOTTSDALE, AZ 85254
T: 480 948-8754
F: 602-753-9543

One-Time Authorization Health Insurance Claim Form / Pain Sheet

Name of Patient: _____ Insurance ID# _____

Please Indicate:

☐ Left Foot / Ankle ☐ Right Foot / Ankle

Reason for visit: _____

_____

Experiencing Pain?

☐ Yes ☐ No

Pain Scale

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Minimal **Worse**

I request payment of authorized MEDICARE/HEALTH INSURANCE BENEFITS to me or on my behalf be directed to Eulano Foot & Ankle. I authorize any holder of medical information about me and any information needed to determine these benefits or benefits for related services, to be released to MEDICARE/HEALTH INSURANCE BENEFITS and its agents.

Initials: _____

Signature of Parient: _____ Date: _____

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Please carefully read and initial by each statement and sign below.

1._____ I understand if I DO NOT have any insurance card, referral, and/or co-payment, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

2._____ I understand that if I am unable to make a scheduled appointment I need to contact Eulano Foot & Ankle P.C. at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. A $50 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 24 HOUR ADVANCE NOTICE.

3._____ I understand there will be NO RESULTS or SURGICAL PLANNING provided via phone, email or otherwise. The patient is entitled to their written reports but it will not include interpretation by any staff member, other than the treating physician.

4._____ I understand there will be $50 fee for all FMLA and disability paperwork to be filled out and will be completed within 5-7 business days.

5._____ Request for pain medication refills will be reviews for necessity. Refills WILL NOT be filled same day if requested after 2pm Monday thru Thursday otherwise please allow 2 business days to process your refill request. We DO NOT fill prescriptions on Fridays.

6._____ Eulano Foot & Ankle P.C. policy is to collect any co-pay, co-insurance and noncovered fees at the time of service. I understand that if I do not have my responsible amount, my appointment may be rescheduled.

7._____ As a courtesy to our patients,Eulano Foot & Ankle, P.C. will bill your insurance company. If payment is not received from your insurance company within 60 days of your visit, you will be notified to contact your insurance for payment. If payment is not received from your insurance company within 90 days of your visit, you will receive a statement notifying you that the balance due is your responsibility.

8._____ I understand I will have 30 days to make payment in full or make payment arrangements. If the account is not paid within 120 days of your visit, your account will be sent to a collection agency and a 35% collection fee will be added to the balance on the account. Incidental costs incurred in the process collection a balance will also be added to your account.

9._____ I understand that Eulano Foot & Ankle P.C. will collect, 24 hours prior to any surgery or procedure, deductibles and coinsurance up to any amount equal to payment in full for the planned surgical procedure. Payment in full and expected coinsurance payment responsibility are determined by the anticipated surgical billing code(s), details of your insurance policy, and agreement between your insurance company and Eulano Foot & Ankle, P.C.

10._____ I understand I am financially responsible for all copayments, coinsurance, deductibles and any unpaid or denied services not covered by my insurance: TO INCLUDE DURABLE MEDICAL EQUIPMENT, IN OFFICE PROCEDURES OR ANYTHING SIMILAR.

11._____ I understand that a $35 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.

12._____ Eulano Foot & Ankle, P.C. will contact my insurance company to verify benefits however, insurance company's do not disclose all information regarding policies. I understand it is my responsibility to contact my insurance provider to confirm actual benefits, coverage, inclusions and exclusions. If I required a referral, it is my responsibility to obtain the referral authorization from my insurance carrier and provide that information to our office.

I have read, and I understand the above office policies and I agree to abide by its terms.

Printed Name of Patient	Signature	Date

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Effective as of March/1/2010

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This HIPAA Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may required that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

We may use of disclose your protected health information in the following situations without your authorization. These situations include as required by law, public health issues as required by law, communicable disease, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164-500.

I understand that I have the right to request and receive a Notice of Privacy Practices from Eulano Foot & Ankle P.C. at any time.

_____ _____

Signature Date

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Assignment of Benefits Financial Responsibilities

Patient Name: _____ Phone: _____

DOB: _____ Age: _____ ☐ Male ☐ Female SS# _____-_____-_____

Email: _____ Address: _____
Street

_____ _____
City State Zip

Medical History

Do you have any history of (please check box):

☐ Diabetes	☐ Phiebitis	☐ HIV / AIDS	☐ Emotional Problems
☐ High Blood Pressure	☐ Tubercolosis	☐ Asthma	☐ Other serious illness
☐ Hyperthyroid	☐ Valley Fever	☐ Rheumatic Fever	_____
☐ Heart Problems	☐ Anemia	☐ Bursitis	_____
☐ Epilepsy	☐ Kidney Problems	☐ Poor Circulation	_____
☐ Arthritis	☐ Liver Disease	☐ Pneumonia	_____
☐ Stroke	☐ Cancer	☐ Bronchitis	_____

Have you experienced any trauma, i.e. broken bones, automobile accidents? ☐ Yes ☐ No

Please describe _____

_____

Do you smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

What type? ☐ Wine ☐ Beer ☐ Hard Liquor

Are you currently using any over the counter medications? _____

Do you experience leg cramps? _____ Low back pain? _____

Stiffness in feet or legs? _____ Numbness in feet or legs? _____

Swelling of feet or legs? _____

Thank you for this information. It is vital in helping us to help you.

_____ _____
Patient Signature Date

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INSURANCE INFORMATION

PRIMARY

Ins: _____ Policy Holder: _____

Policy / ID #: _____ DOB: _____

Group #: _____ Phone: _____

SECONDARY

Ins: _____ Policy Holder: _____

Policy / ID #: _____ DOB: _____

Group #: _____ Phone: _____

Emergency Contact: _____

Phone #: _____ Relationship: _____

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT BENEFITS

1. I understand that I am responsible for charges not covered or reimbursed by the health insurance. I agree in the event of nonpayment, or partial payment, to assume the cost of interest, collection, and legal action (if required).

2. I authorize my insurance carrier to release information regarding my coverage to Eulano Foot & Ankle P.C.

3. My right to payment for all pharmaceuticals, procedures, tests, medical equiptment rentals, supplies and nursing / physician services including major medical benefits are hereby assigned to Eulano Foot & Ankle P.C. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance, third party liability claims, medical liens, attorney based claims or any other health plans.

4. Acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Eulano Foot & Ankle P.C.

_____ _____

SIGNATURE DATE

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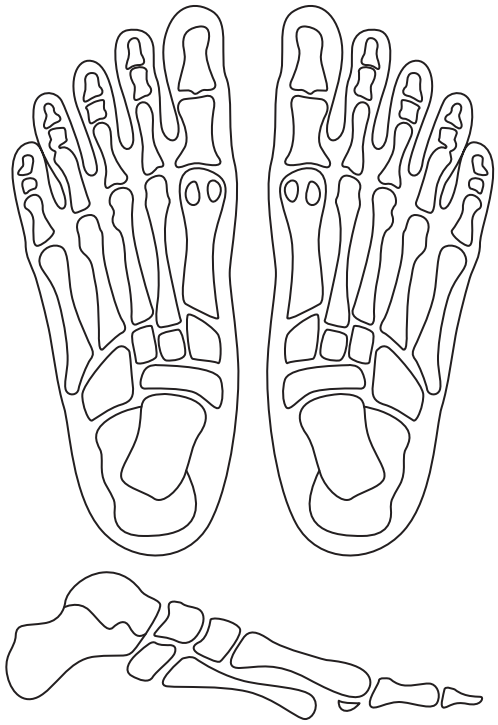
PLEASE CIRCLE WHERE YOUR PAIN IS ON THE FOLLOWING DIAGRAM AND INDICATE TYPE"

for Numbness
+ for Pins & Needles
= for Stabbing Pain
\\ for Aching Pain

Describe current complaints: _____



Assignment and Release:

I, the undersigned have _____ insurance, and assign directly to Dr. Albert E. Eulano all medical benefits, if any, otherwise payable to me for any services rendered. I understand that I am financially responsible for all charges wether or not paid by insurance. I hereby authorize the doctor to release information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
SIGNATURE OF INSURED/GUARDIAN DATE

Medicare Authorization:

I request that payment of authorized Medicare benefits be made to Dr. Albert E. Eulano for any services furnished to me by that physician. I authorize the holder of medical information about me to release to Healthcare Financing Administration and its agents any information needed to determine these benefits of the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms of electronically submitted claims my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept theSOINSURANCE TO CO-INSURANCE. Coinsurance and the deductable are based upon the charge determination of the Medicare carrier.

_____ _____
SIGNATURE OF INSURED/GUARDIAN DATE

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Patient Name: _____ Date: _____

List Current Medications OR see attached list:

_____

_____

_____

_____

_____

_____

_____

Medication Allergies:

_____

_____

_____

_____

_____

_____

_____

_____ _____

Patient Signature Date