FLAGSTAFF FOOT DOCTORS

DR. ANTHONY ROSALES, D.P.M.

PATIENT INFORMATION SHEET

Last Name: _____ First Name/MI: _____
Address (street): _____ P.O., Box: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____ Cell Phone: _____ Email: _____
Sex: (circle one) Male or Female Marital Status: _____ Birthday: _____ Age: _____
Social Security #: _____ Height: _____ Weight: _____ Shoe Size: _____
Employer: _____ Address: _____
Work Phone: _____ Occupation: _____

Insurance Policy Holder (if other than patient):

Last Name: _____ First Name/MI: _____
Relationship to Patient: (circle one) Wife Husband Parent Other
Policy No: _____ Grp #: _____
Address (street): _____ PO Box: _____
City: _____ State: _____ Zip Code _____
Phone #: _____ Birthday: _____ Social Security #: _____
Employer: _____ Work Phone: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Responsible Party (if other than the patient):

Name: _____ Relationship to patient: _____ Phone#: _____

Who referred you to our office? _____

MEDICAL INFORMATION

Please describe your foot problem: _____
List all medications you are taking: _____
_____
List all allergies to medications: _____
List all Surgeries: _____
_____
Medical History: _____
_____
Primary care physician: _____ Phone: _____
Does patient use: Alcohol: _____ Non-Prescription Drugs: _____
Has the patient ever been a smoker? (circle one) Current smoker Never Smoker Former Smoker

Preferred Pharmacy (Name and Zip Code): _____

I authorize the release of medical information necessary to process any claim. I authorize payment of benefits to myself, DR. ANTHONY ROSALES, as agreed upon at the time of treatment for services rendered. I assume responsibility for payment of my account. I will be responsible for all collection costs, interest, court or attorney fees.

Signature: _____ Date: _____

FLAGSTAFF FOOT DOCTORS

Dr. Anthony Rosales, D.P.M., P.C.

PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. It is your responsibility to have a referral sent to our office for all HMO plans prior to your appointment. Failure to do so may result in you having to pay for your visit.

- Unless other arrangements have been made in advance by you, or your health carrier, payment for office services are due at the time of service. **You must provide our office with a photo ID and Insurance card upon check in. Failure to provide a photo Id and Insurance card will result in you having to pay for your visit.** We will accept VISA, Mastercard, Discover, cash or check.

- **Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 30 days from your date of service, we will have to look to you for payment. Claims will not be resubmitted with different codes if they have been denied due to lack of coverage.**

- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.

- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges for any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered. **It is your responsibility to verify coverage and benefits for all services including labs ordered, imaging and procedures performed and to know the limits and exclusions of your insurance coverage.**

- You must inform the office of all-insurance changes and authorization/referral requirements prior to your visit. In the event the office is not informed, you will be responsible for any charges denied.

- There are certain elective surgical procedures for which we require prepayment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the procedure.

- Past due accounts are subject to collection proceedings. Additional billing statements will incur a $10 fee. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

- There is a service fee of $50.00 for all returned checks. Your insurance company does not cover this fee. ALL Credit, Debit and HSA card transactions have an additional 3% fee.

- **There is a $75.00 fee for all no show appointments AND cancellations not done 24 hours in advance. If you choose to leave your appointment prior to seeing the Doctor this will be an automatic same day cancellation and the fee will be applied.**

Signature of Patient/Responsible Party:_____ Date:_____

Printed Name of Patient/Responsible Party:_____

FLAGSTAFF FOOT DOCTORS

Dr. Anthony Rosales, DPM, PC

421 N. Humphreys Street • Flagstaff, Arizona 86001 • (928) 774-4825 • Fax (888) 464-1135

Welcome to Flagstaff Foot Doctors, home of the " Happy Feet"! Our goal is to provide you with the most up-to-date medical service available in a professional environment and in a timely fashion. In order to do so, certain tests and or procedures may be required that may not be covered by insurance. These tests and/or procedures are not mandatory but may be highly recommended. In the event you have not met your deductible or the service is a non-covered benefit, payment will be collected at time of service. If you leave prior to your scheduled appointment time it will be considered as a same day cancellation and a fee will be assessed. It is your responsibility to know your insurance coverage. Listed below are some of the services that we provide that may or may not be covered.

They include, but are not limited to:

- Office visits or procedures performed during office visits
- Orthotics
- OCT insert
- Braces/AFO
- CAM Walker
- Surgical shoes
- Ankle braces
- Night Splints
- Cortisone Injections
- Stem cell injections
- Nerve blocks
- Biopsies of skin or nail
- Ingrown nail procedures
- Nail debridement
- Callus debridement
- Wart treatment
- Wound debridement
- Unna boots
- Hammer toe or bunion procedure
- Ultrasound(s) or X-Rays
- Taping
- Casting
- Other treatments/services, dispense durable medical equipment
- Vascular Test/ Nerve Test

I authorize the physicians of Flagstaff Foot Doctors to perform any of the in-office procedures listed above. This agreement to pay will remain in effect indefinitely, unless revoked. Thank you for your understanding and we look forward to providing you with the best possible medical care.

Signature _____ Date _____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

CREDIT CARD PAYMENT FORM

I hereby authorize Flagstaff Foot Doctors to retain my credit/debit or HSA card information on file for the purpose of settling any outstanding copayments, deductibles, and/or coinsurance balances that I may incur. I certify that I am an authorized user of this credit card and agree to payment in full for all due balances. I further agree not to dispute any transaction with my financial institution, provided that said transaction aligns with the terms stipulated in this form. I understand and acknowledge that a 3% processing fee will be applied to all transactions.

CARD TYPE: ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ HSA

NAME ON CARD: _____

CARD # _____

EXP DATE_____ CVC: _____

BILLING ADDRESS: _____

ZIP CODE: _____

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

FLAGSTAFF
FOOT DOCTORS

SOCIAL MEDIA RELEASE

I grant permission for Flagstaff Foot Doctors, Anthony Rosales DPM at 421 North Humphrey's Street, Flagstaff, Arizona, 86001, the rights of my foot/leg images, in video or still, and of the likeness and sound of my voice as recorded on audio or videotape without payment or other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings and/or for social media within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following uses: media, news (press), online / internet videos, presentations and social media.

By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet, social media or in the public educational setting.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

By signing this release, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Releaser's Signature _____ Date: _____