

WELCOME TO OUR OFFICE

www.alaskapodiatry.com

MY APPOINTMENT IS WITH (CIRCLE ONE):

DR. LA ROSE DR. REED DR. SWAYMAN

PLEASE PRINT

PATIENT INFORMATION

| | | | | | |
|---|----------------------|--------------|----------------------|------------------|----------------------|
| PATIENT'S NAME (F,M,L,) | | SEX | DOB | AGE | SSN (EVEN IF CHILD) |
| MAILING ADDRESS | | CITY | STATE | ZIP CODE | |
| ID# OR DL# | HOME PHONE # | CELL PHONE # | | BUSINESS PHONE # | |
| PATIENT'S OR PARENT'S EMPLOYER | | OCCUPATION | | FULL-TIME | PART-TIME RETIRED |
| | | | | SELF-EMPLOYED | SEASONAL |
| EMPLOYER'S ADDRESS | | CITY | STATE | ZIP CODE | |
| MARITAL STATUS | SPOUSE / PARENT NAME | | ADDRESS IF DIFFERENT | | PHONE# |
| S M W D | | | | | |
| NEAREST LIVING RELATIVE / EMERGENCY CONTACT | | | ADDRESS | | PHONE# |

INSURANCE INFORMATION

| | | | |
|-------------------------|-----------------|-----------------------|--------------|
| PRIMARY INSURANCE CO. | NAME OF INSURED | INSURED'S SSN and DOB | RELATIONSHIP |
| SECONDARY INSURANCE CO. | NAME OF INSURED | INSURED'S SSN and DOB | RELATIONSHIP |
| TERTIARY INSURANCE CO. | NAME OF INSURED | INSURED'S SSN and DOB | RELATIONSHIP |

REFERRED BY: _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT OR RESPONSIBLE PARTY IS RESPONSIBLE FOR ALL FEES, INCLUDING ANY COSTS INCURRED IN THE COLLECTION OF THESE FEES, REGARDLESS OF INSURANCE. I UNDERSTAND THAT ALL OUTSTANDING BALANCES ARE DUE AFTER 60 DAYS REGARDLESS OF INSURANCE STATUS.

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)

I HEREBY AUTHORIZE ALASKA PODIATRY ASSOCIATES TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THEM ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS, I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

SIGNATURE _____

DATE _____

MEDICAL HISTORY

Height: _____

Weight: _____

Shoe Size: _____

1) Please describe your foot problem: _____
_____ Duration _____

2) Who is your Primary Care Physician?

3) Have you been in the hospital in the past two years? YES NO

4) Please list medications:

5) Please list allergies:

6) Have you ever had any excessive bleeding requiring treatment? YES NO

7) Women: Are you pregnant now? YES NO
Do you anticipate becoming pregnant? YES NO

8) Do you smoke or chew tobacco? YES NO
Times per day: _____

9) Please circle any of the following which you have had or have at present:

- | | | |
|-----------|----------------------|-----------------------|
| AIDS | Heart Disease/Attack | Cancer |
| Diabetes | Allergies or Hives | Drug Addiction |
| Ulcers | High Blood Pressure | Rheumatic Fever |
| Anemia | Epilepsy/Seizures | Fainting/Dizzy Spells |
| Stroke | Kidney Disease | Varicose Veins |
| Asthma | Liver Disease | Blood Clots |
| Glaucoma | Arthritis | Hemophilia |
| Hepatitis | Emphysema | Skin Disease |

10) Do you have any disease, condition, or problem not listed?

11) Previous surgical procedures: _____

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health or medications, I will inform the doctor at the next appointment.

DATE: _____ NAME (print) _____ SIGNATURE _____

ALASKA PODIATRY ASSOCIATES
dba ALLIANCE FOOT & ANKLE

Carol F. La Rose, D.P.M.
Michael Reed, D.P.M.
Kenneth C. Swayman, D.P.M.

2741 DeBarr Road, Suite C-315
Anchorage, AK 99508
(907) 562-4958

SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions.
- I authorize release of pertinent information to all my insurance companies.
- I understand that I am ultimately responsible for my bill.
- I understand all outstanding balances are due after 60 days regardless of insurance status.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- I authorize payment direct to my doctor.
- I permit a copy of this authorization to be used in place of the original.

Print Name: _____ S.S.# _____

Signature: _____ Date: _____



ALLIANCE FOOT & ANKLE BILLING POLICY

Dr. Swayman, Dr. La Rose and Dr. Reed are preferred providers with Blue Cross, Aetna, and Tricare. We bill all insurance(s), but we only accept adjustments from these three companies. We do require your 20% or co-pay at time of service. We also require payment up to your deductible, if deductible has not been met.

If you have Workman's Compensation, we do not require payment. We will bill Workman's Compensation as long as we have the claim number, date of injury, adjuster name and phone number, name of employer in which the accident took place, and billing address **at time of service.**

*We require all insurance information at time of service to bill. Primary, secondary, and tertiary insurance companies will be billed as long as we have the information prior to treatment. **We will not bill any insurance company after treatment if it was not provided before treatment.***

DURABLE MEDICAL EQUIPMENT AND OVER THE COUNTER MEDICINE DISPENSED IN THIS OFFICE:

We require payment in full at time of service, as your insurance company may not cover these items, regardless of insurance.

Medicaid and Denali Kid Care do not cover these items. If purchased, payment is required in full at time of service and the equipment is not filed with these two insurance companies.

We are not a DME provider with Medicare. We cannot bill Medicare Cigna supplies as we do not have a registered number with them. If you purchase these items, we require payment in full at time of service and we will not file with Medicare.

REFUNDS:

We only send refund checks if the credit is \$30.00 or more. We will hold the credit under \$30.00 on file unless you call and request the credit be refunded to you. We charge a \$2.00 fee for postage and handling of all refunds.

If you have any questions, please feel free to ask the front office staff or manager.

Please read carefully. By signing this form you acknowledge that you understand our billing policies.

Patient Name: _____ Date: _____

Patient / Parent or Guardian Signature: _____



ACKNOWLEDGEMENT 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 choose) and understand the Notice.

Patient Name (please print)

Date

Parent or Authorized Representative Name (please print, if applicable)

Signature