



**PATIENT UPDATE FORM**  
*\*PLEASE COMPLETE ALL INFORMATION*

**DEMOGRAPHIC INFORMATION**

NAME: First: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female  Undifferentiated

Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Retired  Student  Employed Employer: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

EMAIL Address: \_\_\_\_\_

How do you prefer to be contacted?  E-mail  Mail

Emergency Contact: \_\_\_\_\_ Emergency Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Primary Card Holder: \_\_\_\_\_ Secondary Card Holder: \_\_\_\_\_

Card Holder DOB: \_\_\_\_\_ Card Holder DOB: \_\_\_\_\_

Member #: \_\_\_\_\_ Member #: \_\_\_\_\_

Group #: \_\_\_\_\_ Group #: \_\_\_\_\_

**PRIMARY CARE INFORMATION**

Primary Care Doctor (Who provides your health care): \_\_\_\_\_

Office #: \_\_\_\_\_ Date of the last visit: \_\_\_\_\_

**MISCELLANEOUS**

Primary Pharmacy: Name: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**MEDICAL/SOCIAL HEALTH INFORMATION**

Please list any current medical conditions: \_\_\_\_\_

\_\_\_\_\_

Please list all medications that you are currently taking: \_\_\_\_\_

\_\_\_\_\_

Triangle Foot and Ankle Specialist strive to render excellent medical care to you and to the rest of our patients.

OUR POLICIES ARE AS FOLLOWS

1. PAYMENTS:

- When verifying benefits, it is never a guarantee of payment per your insurance company's disclaimer. You are responsible for all co-pays, deductibles, co-insurance amounts and non-covered services. The Patient/Guardian is aware that their insurance company may not make payment on a claim and that it will be the Patient's/Guardian's responsibility to do so.
- Your visits will be coded based on documentation from your provider during the visit, which may not be covered by your insurance carrier at 100%. Diagnosis codes will not be changed in an attempt to reduce out of pocket expenses.

2. CO-PAYS, CO-INSURANCE and DEDUCTIBLES:

- All Co-Pays are due at the time of today's appointment prior to seeing the doctor.
- Account balances are to be paid in full at the time of today's appointment prior to seeing the doctor.
- Deductibles, Co-insurance and any additional charges will be collected at the time of check out. You are ultimately responsible for payment of charges for services from our office.
- It is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit.
- If your plan requires a referral, it is your responsibility to obtain this prior to being seen.
- It is our desire to help you as much as possible with claims that are submitted to your insurance company. If procedures are done in the office that are deemed non-covered by your insurance company, you will be responsible for the payment.
- Unpaid previous balances must be paid in full prior to any additional visits, unless arrangements have been made with the billing office.
- Returned check fee is **\$25.00**.
- **The Patient will be responsible for all Attorney Fees, Legal Fees and Court Cost if the account is turned over to collections.**
- **If the Patient is a minor the Patient's Legal Guardian will be responsible for all Attorney Fees, Legal Fees and Court Cost if the account is turned over to collections.**

3. CANCELLATIONS:

- When an appointment is scheduled, that time has been set-aside for you and when it is missed, that time cannot be used to treat another patient.
- Cancellations for appointments and procedures must be received 24 hours prior to the scheduled appointment. You may leave a **24-hour** cancellation message on the answering machine.
- ***Patients who fail to keep or cancel a scheduled appointment will be charged a \$25.00 No-Show/No-Call Fee.*** (We make reminder calls as a courtesy, but it is your responsibility to keep track of your appointment).
- Cancellations for scheduled surgery must be received at least **72 hours** prior to the schedule surgery date and time.
- A **\$250.00** deposit is required at time of scheduling a surgery. Once your account has been paid in full and if you are due a refund, one will be issued to you upon request.

- Patients who fail to keep or cancel a scheduled surgery less than 30 days before the scheduled surgery will not be refunded the \$250.00 surgery deposit, regardless of when the surgery was scheduled.

4. MEDICAL RECORDS:

- Medical Records request must be received at least **48 hours** prior to the date needed.
- There is a non-refundable **fee of \$25.00** for requested copies of medical records.
- There is an additional non-refundable **fee of \$25.00** for requested copies of medical X-rays.
- Fees for medical are set in accordance as defined by the State of North Carolina.
- **WE DO NOT FAX MEDICAL RECORDS TO PATIENTS OR FAMILY.**
- Fees must be paid prior to mailing or pick up of medical records.

5. REFUNDS: (Pertain to Insurances Only)

- An insurance company has Ninety Days to process your claim. Even after the Ninety Days the insurance company may still be processing your claim.
- Once we have received confirmation and payment from your insurance company and the remaining balance on your account is paid in full, upon request a refund check will be issued within **30 days**.

6. RETURNS:

- We do not accept returns or cancellations for any reason on **custom orthotics, over the counter orthotic inserts or medical products** that have been dispensed to you by the doctor in the office.
- HIPAA and NC Health Regulations **prohibit** the **return** of these products.

7. SUMMARY / STATEMENTS:

- Your summary will be ready for you at then end of your visit.
- Your statement is mailed to you the first week of the month.
- If you do not have a balance, you will not receive a statement.

By signing you fully understand your rights and responsibilities.

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_