PATIENT ANNUAL UPDATE FORM

PLEASE COMPLETE ALL INFORMATION

DEMOGRAPHIC INFORMATION

NAME: First: ___________________________ **MI:** _________ **Last:** ____________________________

Date of Birth: __________________________________ **Gender**: □ Male □ Female

Ethnicity: ________________________________ Preferred Language: ____________________________

Social Security #: ___________________________________

Address: ____

City: ________________________________ State: _______________ Zip: ________________________

Home #: ____________________ Work #: ____________________ Cell #: _____________________

EMAIL Address: ____

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

Emergency Contact: ___________________________ Emergency Phone #: ________________________
Relationship to patient: __________________

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: ______________________

MICSELLANEOUS

Primary Pharmacy: Name: ________________________________ Zip: __________ Phone: ________

MEDICAL/SOCIAL HEALTH INFORMATION

Any changes to your medical history? (Please Explain): _________________________________

____

List any changes to your medications: ____

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:_____________