

# Momentum Foot & Ankle

MOVEMENT STARTS HERE



## New Patient Packet

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex:  Male  Female  Other

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

Phone: (Cell) \_\_\_\_\_ (Home) \_\_\_\_\_ Email: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy City: \_\_\_\_\_

What specific issue brings you to our office today? \_\_\_\_\_

Foot Pain  Ankle Pain  Fungal Nails  Soft Tissue Mass  Diabetic Foot Care

Ulcer(s)  Rash  Bunion  Orthotics  Flat foot

Other: \_\_\_\_\_

Pain/Problem Location \_\_\_\_\_

How long ago did the issue begin? (Days/Weeks/Months/Years) \_\_\_\_\_

Was this caused by an injury?  No  Yes Describe: \_\_\_\_\_

Was it work related:  No  Yes Date of Injury: \_\_\_\_\_

How did the issue develop?  Started suddenly  Gradually worsened over time

How would you describe your pain?  None  Sharp  Dull  Aching  Burning  Shooting

Other: \_\_\_\_\_

Rate your pain on a scale from 0 to 10 (circle): (0 = No Pain, 10 = Worst Pain Possible)

0 1 2 3 4 5 6 7 8 9 10

How did you hear about us?  Instagram  Facebook  Friend  Referral \_\_\_\_\_

## Past Medical History

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Asthma	<input type="checkbox"/> Chronic Kidney Dz
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Edema	<input type="checkbox"/> Dialysis
<input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Insulin <input type="checkbox"/> Oral Meds	<input type="checkbox"/> Heart disease <input type="checkbox"/> Heart Attack <input type="checkbox"/> A Fib <input type="checkbox"/> CHF	<input type="checkbox"/> Vascular Disease <input type="checkbox"/> PVD <input type="checkbox"/> Venous Disease <input type="checkbox"/> History DVT
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Arthritis	<input type="checkbox"/> GERD
<input type="checkbox"/> Ulceration	<input type="checkbox"/> Cancer	<input type="checkbox"/> Depression
<input type="checkbox"/> Lung Disease <input type="checkbox"/> COPD	<input type="checkbox"/> Coronary Artery Dz <input type="checkbox"/> Stroke	<input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Hyperthyroidism
<input type="checkbox"/> Gout	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Autoimmune Dz

Other: \_\_\_\_\_

## Past Surgical History

Surgeries	Date	Complications

Have you ever had general Anesthesia: [ ] Yes [ ] No

Have you had any problems with anesthesia? \_\_\_\_\_

## Medications

(Include non-prescription, such as aspirin, herbal medications, vitamins)


## Allergies

Medication	Describe Reaction

Are you allergic to shellfish or iodine? [ ] No [ ] Yes

Are all your immunizations up to date? [ ] No [ ] Yes

## Family History:

Member	Alive/Deceased	Age	Pertinent Health History

## Social History:

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Shoe size: \_\_\_\_\_

### Smoking Status

Do you currently smoke?  No  Yes

How much? \_\_\_\_\_ packs per day. For \_\_\_\_\_ years.

Have you quit smoking?  This year  More than 1 yr  More than 5 yr  More than 10 years

If you previously smoked: \_\_\_\_\_ packs per day for \_\_\_\_\_ years.

### Alcohol Use

Do you drink alcohol?  No  Yes – How much? \_\_\_\_\_ drinks per day \_\_\_\_\_ drinks per week

### Substance Use History

Do you have a history of substance use or abuse?  No  Yes

If Yes, Please specify: \_\_\_\_\_

### Emergency Contacts

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

# FINANCIAL AGREEMENT POLICY

We are committed to providing high-quality care to all of our patients. To ensure smooth processing of payments for services rendered, we ask that you carefully review and sign this Financial Agreement Form.

## **Patient Financial Responsibility**

As a patient at MOMENTUM FOOT & ANKLE, you are financially responsible for all charges incurred during your treatment. This includes co-pays, deductibles, coinsurance, and any non-covered services. Payment is due at the time of service. If your insurance plan does not cover certain services, you are responsible for paying the balance.

## **Insurance and Billing**

We will verify your insurance information and submit claims on your behalf. However, if your insurance denies a claim or if there is any remaining balance after insurance payment, you are responsible for payment. It is your responsibility to provide accurate and up-to-date insurance information at each visit and notify us of any changes.

## **Payment at Time of Service**

All co-pays and out-of-pocket expenses are due at the time of your visit. If you do not have insurance, full payment is required at the time of service. Payment plans are available by request and must be agreed upon before services are rendered.

## **Missed Appointments/No-Show Policy**

Failure to cancel an appointment with at least 24 hours' notice will result in a no-show fee. This fee must be paid before rescheduling any future appointments.

## **Collection of Unpaid Balances**

If your account becomes past due, MOMENTUM FOOT & ANKLE may refer your account to a collection agency, and you will be responsible for any additional costs, including collection fees or attorney fees.

**Authorization for Insurance Benefits**

By signing below, I authorize **MOMENTUM FOOT & ANKLE** to submit claims to my insurance company for services provided. I assign my medical benefits to **MOMENTUM FOOT & ANKLE** and authorize the release of any necessary medical information to process my claims.

**Acknowledgment and Agreement**

I understand that I am financially responsible for all charges incurred during my treatment and that payment is due at the time of service. I agree to provide accurate insurance information and understand that I will be responsible for any balances not covered by insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

For Minors or Legal Guardians (if applicable):

Guardian Name: \_\_\_\_\_

Guardian Relationship to Patient: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# NO SHOW POLICY

At **MOMENTUM FOOT & ANKLE**, we strive to provide the highest quality care to all our patients. To ensure that we can accommodate everyone effectively, we have established the following policy for missed appointments and late cancellations:

## Definition of a No-Show or Late Cancellation

A no-show occurs when a patient misses an appointment without prior notice. A late cancellation is when a patient cancels or reschedules their appointment less than 24 hours before the scheduled time.

## Importance of Keeping Appointments

When a patient misses an appointment, it prevents us from offering that time slot to another patient in need of care. Your cooperation helps us maintain efficient scheduling and provide the best service for everyone.

## No-Show/Late Cancellation Fees

Patients who miss an appointment or cancel with less than 24 hours' notice may be charged a \$35 fee. This fee is not covered by insurance and must be paid before scheduling a new appointment.

## Exceptions

We understand that emergencies and unforeseen circumstances happen. If you miss an appointment due to an emergency, please contact our office as soon as possible, and we may waive the fee at our discretion.

## Repeat No-Show Policy

First No-Show: A courtesy call will be made to remind you of our policy. Second No-Show: The fee will be applied to your account, and future appointments will require confirmation.

**Reminders To help you keep your appointments:**

We offer appointment reminder calls, emails, or text messages. You also have the option to confirm or reschedule appointments through our online patient portal or by phone.

**How to Cancel or Reschedule**

If you need to cancel or reschedule your appointment, please contact our office at **843-954-3308** at least 24 hours in advance. This allows us to offer your time slot to another patient.

**Acknowledgment and Agreement**

By signing below, you acknowledge that you have read and understand our No-Show and Late Cancellation Policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

For Minors or Legal Guardians (if applicable):

Guardian Name: \_\_\_\_\_

Guardian Relationship to Patient: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# AUTHORIZATION/CONSENT FORM

## INSURANCE

We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. **MEDICARE:** We are a participating Medicare provider. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible and any Copayments, which are usually 20% of the allowed amount for an item or service. If you have a **SECONDARY INSURANCE** Your medical claim will be forwarded after payment and/or explanation of benefits (EOB) is received from your primary insurance company

## Authorization to Release Information / Assignment of Medicare Benefits

- **Medicare/Insurance Authorization:** I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries, or carriers any information needed for this or any related Medicare/Insurance claim(s).
- **Assignment of Benefits:** I request that payment of authorized medical insurance benefits be made on my behalf to **MOMENTUM FOOT & ANKLE** for any services furnished to me by the provider.
- **Certification:** I certify that the information provided by me in applying for payment under Title XVIII of the Social Security Act is correct.
- **Duration:** I permit a copy of this authorization to be used in place of the original. This is a lifetime authorization that remains in effect until revoked by me in writing.

Initial here: \_\_\_\_\_

## Assignment of Insurance Benefits / Release of Information

I authorize **MOMENTUM FOOT & ANKLE** to:

- Release necessary information, including diagnosis and records of my treatment, to my insurance company or its representatives.
- Direct my insurance company to pay **MOMENTUM FOOT & ANKLE** for services rendered.

Initial here: \_\_\_\_\_

### **Financial Responsibility**

- I understand that I am financially responsible for any charges not covered by my insurance.
- I agree to pay all copayments and coinsurance at the time of service.

Initial here: \_\_\_\_\_

### **Referrals and Authorizations**

- I understand it is my responsibility to obtain all necessary referrals or authorizations for treatment.
- Visits may be rescheduled if proper authorization is not secured beforehand.

Initial here: \_\_\_\_\_

### **Consent to Treat**

I authorize **MOMENTUM FOOT & ANKLE** to:

- Perform diagnostic tests, including x-rays or other aids, to ensure a thorough diagnosis.
- Proceed with recommended treatments, medications, and therapies as mutually agreed upon.

I understand:

- There are risks associated with anesthetic agents.
- I am fully responsible for payment of medical services rendered, unless prior arrangements are made.

I agree to notify the office of any changes to the information provided.

Initial here: \_\_\_\_\_

### **Medical Release**

- A photocopy of this form is sufficient to authorize any person holding medical records to release true copies to **MOMENTUM FOOT & ANKLE** or insurance providers as needed.

Initial here: \_\_\_\_\_

### **Liability Waiver**

I release **MOMENTUM FOOT & ANKLE** , its employees, and affiliates from any claims arising from:

- Loss or damage to personal valuables.
- Refusal of emergency services, including ambulance or physician care.

Initial here: \_\_\_\_\_

### **Insurance**

- I agree to provide necessary insurance information at each visit.
- I understand my insurance policy is an agreement between myself and the insurance company, while my physician's bill is an agreement between myself and **MOMENTUM FOOT & ANKLE**
- If my insurance company does not cover services, I am responsible for full payment.
- Patients without health insurance are required to pay in full at the time of service.

Initial here: \_\_\_\_\_

## Notice of Privacy Practices (HIPAA)

MOMENTUM FOOT & ANKLE is committed to protecting your health information. We use and disclose your Protected Health Information (PHI) to:

1. Treat you: Sharing info with your primary doctor or specialists.
2. Get Paid: Sending info to your insurance company for billing.
3. Operate our Practice: Internal quality reviews and scheduling.

**Patient Rights:** You have the right to inspect your records, request an amendment, and receive an accounting of disclosures. We will not sell your information or use it for marketing without your written authorization.

I acknowledge that I have been offered/received a copy of this office's Notice of Privacy Practices.

I authorize MOMENTUM FOOT & ANKLE to send appointment reminders and clinical updates via SMS/Email.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

