

Dr. Jesse Riley, DPM
Elevated Foot + Ankle

Patient Information

Patient Name:_____

Age:_____ **Sex:** M/F/Other **Pronouns:** He/Him She/Her They/Them

Date of Birth:_____

Home Address:_____

Mailing Address (if different)_____

City:_____ **State:**_____ **Zip:**_____

Cell Phone:_____ **Home Phone:**_____

Email Address:_____

May we send you texts or emails? Yes / No

Marital Status: Single Married Divorced Widowed

Employer name/School name:_____

Social Security Number:_____

Family Doctor:_____ **Approximate date of last visit:**_____

If Diabetic, most recent A1C number:_____

Insurance Company:_____

Emergency contact (or parent/legal guardian if you are under the age of 18)**:**

Contact Name:_____ **Phone:**_____

Relation:_____

Address:_____ **City:**_____ **Zip:**_____

How did you hear about us?

- ☐ Google
- ☐ Facebook
- ☐ Instagram
- ☐ Insurance
- ☐ Doctor's Office:_____
- ☐ Friend:_____
- ☐ Mailer:_____
- ☐ Other_____

Which Foot do you have complaints about? **Left foot/ Right foot/ Both feet**

What is the nature of your foot complaint?_____

_____

_____

What have you done for this condition?_____

_____

When does it hurt the most:_____

_____

Approximately when did the condition start?_____

Preferred Pharmacy:_____

Are you generally in good health? yes / no

If female, are you now pregnant? yes / no

Height:_____

Weight:_____

Shoe Size:_____

Past medical history - Do you have or have you had any of the following:

	Yes	No		Yes	No
Diabetes	☐	☐	Heart Disease/Heart Attack	☐	☐
Acid Reflux (GERD)	☐	☐	HIV/AIDS	☐	☐
Arthritis	☐	☐	High Blood Pressure	☐	☐
Asthma	☐	☐	Low Blood Pressure	☐	☐
Back Problems	☐	☐	Nervousness/Anxiety	☐	☐
Bleeding Disorder	☐	☐	Rheumatic Fever	☐	☐
Cancer:_____	☐	☐	Seizures/Seizure Disorder	☐	☐
Depression	☐	☐	Skin Problems:_____	☐	☐
Gout	☐	☐	Stroke	☐	☐
Hayfever	☐	☐	Thyroid Problems	☐	☐
Hepatitis	☐	☐	Varicose Veins	☐	☐
			Other:_____	☐	☐

Allergies

	Yes	No		Yes	No
Penicillin	☐	☐	Aspirin	☐	☐
Local Anesthetics	☐	☐	Iodine	☐	☐
Sulfa	☐	☐	Tape/Adhesives/Latex	☐	☐
Codeine	☐	☐	Other:_____	☐	☐

Please List the Medications You Currently Take (Include dosage):_____

_____

_____

_____

Family History (please circle if applicable):

Diabetes High Blood Pressure Heart Disease Bleeding Disorder Anesthesia Problems

Cancer: (what kind?)_____ Other:_____

Social History:

Do you smoke? Yes No If no, have you smoked before? Yes No

If yes, how many packs per day?_____ How long? _____

If you have quit, please indicate the date when:_____

How often do you drink alcohol? Never Occasionally Moderately History of Abuse

Previous Surgeries: (all surgeries - include dates if possible):_____

_____

_____

_____

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Elevated
FOOT + ANKLE

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 so chose) and understand the Notice.

_____ _____

Patient Name (please print) **Date**

_____

Parent or Authorized Representative (if applicable)

_____

Signature

I hereby authorize Foot and Ankle Clinic to furnish my designated insurance carrier all the information concerning my present illness or injury. I authorize benefits under this claim to be made directly to the physician.

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING:

A) I agree that I am responsible for this debt regardless of my insurance and that I will pay any unpaid balance, in full, within 90 days of the date of billing. I agree to pay 18% interest per annum on the unpaid balance, compounded daily. B) In the event that my account is not paid as agreed, I agree to pay a collection agency fee of 33.3% of my unpaid balance in addition to my balance, in the event that my account is delinquent.
C) If the account must be referred to an outside collection agency, and you have opted out of receiving a final notice for the delinquent account by text or email, a letter via certified mail or priority mail will be sent. In sending this letter, a fee of up to $6.00 will be added on top of the 33.3% collection fee when the balance is reported.
D) In the event that it is necessary to commence legal action to collect this bill, I agree to pay reasonable attorney's fees and costs of court and agree to submit to the jurisdiction of the Third Circuit Court, Salt Lake City, State of Utah.
E) If any portions of a bill for the provider's services are disputed, I agree to submit myself to mediation or arbitration and will pay the costs incurred in doing so.
F) We want to stay in touch with you regarding your account and its collection status regarding past due balances. In order for us to contact you regarding all past due accounts and any collection status they may have, you expressly authorize us to contact you by telephone or by sending text messages or e-mails at any number or email you have listed. You acknowledge that such contact could result in charges to you by your telephone carrier. Methods of contact may include the use of pre-recorded/artificial voice messages and/or the use of an automatic telephone dialing system, as applicable. You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned.

_____ _____

Signature **Date**

Payment Policy

Thank you for choosing Elevated Foot + Ankle

Please be aware that you are fully responsible for your payment to Elevated Foot and Ankle.

- **You are responsible to contact your insurance company to verify benefits, coverage, and any limitations for podiatry services.**
- Summit Foot and Ankle may contact your insurance as a courtesy, however we cannot guarantee the accuracy of the information.
- You may request a copy of our full Financial Policy at any time for your records.
- **No Show Fee**: If a patient does not show up for a scheduled appointment, a $75 fee will be charged to the patient. Insurance will NOT cover this fee. If you need to cancel or reschedule, please call the office and let us know.

Based on your insurance plan benefits, if you ...

- Have a **Co-payment:**
  - It is due at the time of service.
  - You are seeing a Specialist today, therefore you will be charged the Specialist copay amount.
- Have **Co-Insurance:**
  - We will collect the **ESTIMATED** co-insurance and bill you for the remaining balance.
- Have a **Deductible** (that is not met):
  - **We may collect $100.00 as a down payment** to apply toward your deductible for your visit today.
  - We will then bill you for any remaining balance.
- **Do not have insurance:**
  - We do offer discounts for Self- Pay patients. **Payment for Self- Pay services are due at the time of service.**

I, _____ , have read and understand the full Financial Policy and
(Print Name)
the Payment Policy.

Patient Signature (*Parent/Guardian if under 18*): _____ Date: _____

If you have any questions or concerns regarding your account or payment arrangements, please contact your Account Manager, Ally, at 801-218-3338.