Active Foot & Ankle
Dr. Whitney Holsopple, DPM

300 S. Dorset Rd.
Troy, OH 45373
(937) 875-2526

Name: ______________________ Date Of Birth: ______________________

Address: ______________________ Sex: ☐ Male ☐ Female Marital Status: __________

City, State, Zip ______________________ Race: ______________________

Home Phone: ______________________ Ethnicity (check one): ☐ Hispanic ☐ Latino ☐ Not Hispanic or Latino

Cell Phone: ______________________ Preferred Language: ______________________

Email: ______________________ Family Doctor: ______________________

Employer: ______________________ Preferred Pharmacy: __________ City: __________

Work Phone: ______________________ SS#: ______________________

Primary Insurance Holder Information

Name: ______________________

Relationship: ______________________

Date of Birth: ______________________

SS#: ______________________

Secondary Insurance Holder Information

Name: ______________________

Relationship: ______________________

Date Of Birth: ______________________

SS#: ______________________

Emergency Contact Information: Name: ______________________ Relationship: __________

Phone: ______________________

Today's Problem: ____

How Long: ______________________ Location: ______________________

Severity: (How sever is the pain/problem, circle one) ☐ Mild ☐ Moderate ☐ Severe

I give permission to Active Foot & Ankle to obtain medication history from my local pharmacy, Primary Care Physician, and any other Physician I may have received treatment from.

X-Rays & Photographs: I understand that in the course of my treatment I may have radiographs (X-Rays); I agree to inform the doctor or technologist if I am or may be pregnant. I authorize the physician and his assistant to take photographs. The term "photograph" includes digital, standard photographs, videotapes, etc. These photographs are property of Active Foot & Ankle and will be a permanent part of the record. These may be used for teaching, lectures, educational conferences, or publications.

Patient/Responsible Party Signature: ______________________ Date: __________

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

Last Date of Influenza Vaccine: ____________________ Shoe Size: ________ Height:_______ Weight:________

Last Date of Pneumococcal:_______________________

Have you fallen in the past year? Yes No How many times _________ was there an injury?____________

Allergies to Medications: _____ Yes _____ No If yes, please list below:

____

Non-Medication Allergies: □ latex □ tape □ metal □ adhesive tape □ Iodine

Patient Medical History:

Neuropathy	□ No	□Yes	Ulcer/Wound	□ No	□Yes
Cancer	□ No	□Yes Type_______	Parkinson's	□ No	□Yes
Heart Attack	□ No	□Yes	Arthritis	□ No	□Yes
Heart Disease	□ No	□Yes	Stroke	□ No	□Yes
High BP	□ No	□Yes	Anxiety	□ No	□Yes
Asthma	□ No	□Yes	Depression	□ No	□Yes
Tuberculosis	□ No	□Yes	Diabetes	□ No	□Yes
Hepatitis	□ No	□Yes Type_______	Anemia	□ No	□Yes
Aids/HIV	□ No	□Yes	Clotting Disorder	□ No	□Yes
Kidney Disease	□ No	□Yes	Alzheimer or Dementia	□ No	□Yes

List any surgeries you have had including the date: ____

____

Is there a family history of diabetes: □ No □Yes (If yes, who?) _________________________________

Do you smoke? □ yes □ no How much? ______________ **Do you drink alcohol: □ None □ Occasionally □ Daily**

Do you use drugs: □ yes □ no (Women) Are you currently pregnant? □ yes □ no

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary: By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private

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Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer. I understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, or changed in any way."

I expressly consent to receiving telephone calls from an automatic telephone dialing system, artificial and/or pre-recorded messages, emails, text messages, or other electronic communication from Active Foot and Ankle, and/or their contractors, servicers, debt collection agencies, or agents for any reason by using any telephone number, email address, and/or mailing address associated with my account or obtained by such entities. I agree that my consent may only be revoked by sending a written notice to Active Foot and Ankle or their agents. I agree to arbitrate any claims under the Telephone Consumer Protection Act, and I waive any right/ability to bring a class action against claims, against Active Foot and Ankle, and/or their contractors, servicers, debt collection agencies, or agents. (This is for internal office use only. We do not sell your information to outside companies.)

***I authorize my physician and her staff to communicate information regarding appointments, medical results, and billing issues to the following person(s). Please print name and indicate your relationship.**

Name ______________________________ Relationship ______________________________
Name ______________________________ Relationship ______________________________

Cancellation Policy
Please give a 24 hour notice prior to canceling any scheduled appointment so that we may utilize available appointments for our patients in need of medical care. If you do not cancel your scheduled appointment you will be considered a "No Show" appointment and will be billed a $25.00 no show fee. After three "No Shows" you will be discharged from the practice.
If you arrive 15 minutes past your scheduled appointment time the office has the right to reschedule your appointment.

Patient/Responsible Party Signature: ______________________________ **Date:** ____________________

Self-pay patients - Payment in full is due at the time of service.
Patients with Insurance - We will file your insurance claim for you. However, in order to work with your insurance company, we must have complete and current information as well as a copy of your insurance card and your signature on file.
Denied Claims - You will be responsible for any charges that are denied by your insurance company which result from your failure to provide our office with complete and current information in a timely manner. It is your responsibility to inform us of any changes in insurance benefits.
Referrals- If your insurance requires that you obtain a referral from your Primary Care Physician, it is *your* responsibility to ensure that our office receives the referral prior to your visit. If a referral is not in place, you will be responsible to pay in full at the time of service. If the doctor schedules a test for you, please check with your insurance to see if a prior-authorization is required (as this must be completed before testing is performed). Although we do our best to check for you, it is ultimately the responsibility of the patient.
Durable Medical Equipment- Our office will assist in determining coverage for Durable Medical Equipment (braces, splints, boots, walkers, and/or orthotics as needed). Active Foot and Ankle makes every effort to verify active coverage, but we are not always able to check benefits on all patients, due to regulations of various insurance companies and contract agencies. All processes and procedures must be listed and billed according to HIPPA (Health Insurance Portability and Accountability Act) guidelines by Active Foot and Ankle for accuracy and liability purposes. This means any and all procedures, treatments and care will be billed to you and your insurance. This does not guarantee payment by your insurance company. Any item not covered by insurance is deemed "patient responsibility."
Insurance benefits – It is your responsibility to know your insurance benefits. Please contact your insurance company with any questions that you may have regarding coverage of podiatric services.
Copayments, Co-Insurances and Deductibles – **All patient balances are due at the time of service. Patients with private insurance plans (non-Medicare/Medicaid) that include deductibles will need to pay a $100.00 deposit at the time of service and if the policy has a large deductible exceeding $3000.00 a $75.00 fee will be collected at every visit, along with any balances and copays required by your plan. Active Foot and Ankle reserves the right to refuse treatment if required payments are not made at the time of service. For your convenience, all major credit cards are accepted.**
Non-Covered Charges - Please understand there may be some charges for our services which your insurance company considers non-covered and may be excluded from your policy. Accordingly, you will be responsible for these charges.
Medicare - We are a participating Medicare provider. We will bill Medicare, as well as any secondary insurance that you may have. As per any insurance carrier, this does not mean that all services will be covered. Additionally, if you do not have a secondary insurance, you will be responsible for any copayments (20% of the Medicare allowed amount), as well as any unmet annual deductibles. Please realize that Medicare may allow a service, but your secondary may not, so you will be responsible for that portion.
Returned checks – Any returned check is subject up to a $45.00 bank fee.
Past due accounts – We will send a statement to the mailing address you provide notifying you of any outstanding balances. If you do not respond to the first statement within 30 days of receipt and additional statements are mailed, a $10 re-billing fee will be added each month. If you are not able to pay your balance in full, you must contact out billing office to discuss a possible payment plan. If you then fail to make payments, your account may be referred to a professional collection agency and/or attorney and will be subject to a 35% fee.
I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL POLICY

______________________________ _______________

Signature of Patient or Financially Responsible Date