CAPITAL FOOT & ANKLE, PC
1150 NORTH 83RD STREET
LINCOLN, NEBRASKA 68505
(402) 483-4485

PATIENT INFORMATION FORM

TODAY'S DATE_____

Welcome to our office. Please print clearly and complete both sides of this form. **REFERRED BY**_____

GENERAL

PATIENT INFORMATION

NAME _____ ☐ M ☐ F
(LAST) (FIRST) (MIDDLE) (NICKNAME)

BIRTHDATE _____ SOCIAL SECURITY # _____ MARITAL STATUS _____
(MONTH – DAY – YEAR)

ADDRESS _____ ZIP CODE _____
(STREET) (CITY) (STATE)

HOME PHONE (_____) _____ WORK PHONE (_____) _____ CELL PHONE (_____) _____
(AREA CODE) (AREA CODE) (AREA CODE)

EMPLOYER_____ ADDRESS _____

PREFERRED LANGUAGE _____ RACE _____ ETHNICITY _____

SPOUSE (OR PARENT) INFORMATION

NAME _____ BIRTHDATE _____ PHONE NUMBER (_____) _____

EMPLOYER _____ SOCIAL SECURITY # _____

EMERGENCY CONTACT INFORMATION (OUTSIDE OF HOUSEHOLD)

NAME _____
(LAST) (FIRST) (MIDDLE)

ADDRESS _____ ZIP CODE _____

PHONE NUMBER (_____) _____ RELATIONSHIP TO PATIENT _____

ASSIGNMENT OF PATIENT REPRESENTATIVE

If this form will be signed by a person other than the patient, due to the patient being a minor, being physically or mentally unable to sign, or for any other reason, please complete the following:

REPRESENTATIVE'S NAME _____ ADDRESS _____

RELATIONSHIP TO PATIENT _____ REASON PATIENT UNABLE TO CONSENT _____

INSURANCE

INSURANCE CARRIER INFORMATION

Please list all insurance companies or programs from which you are eligible to receive benefits including such programs as Medicare, Medicaid, TRICARE/CHAMPUS. Please also enter name and date of birth of the insurance policy holder.

Primary _____ Cardholder name/birthdate _____

Secondary _____ Cardholder name/birthdate _____

Tertiary _____ Cardholder name/birthdate _____

I certify I am eligible to receive benefits from the above listed insurance companies/programs, and that I have listed all of my insurance coverage.

PATIENT (OR REPRESENTATIVE) SIGNATURE _____ DATE _____

SELF-PAY INFORMATION

If you (the patient) **do not have insurance** coverage, please complete:

I certify I (the patient) am not eligible to receive benefits from any insurance companies/programs, and will pay in full at the time of service.

PATIENT (OR REPRESENTATIVE) SIGNATURE _____ DATE _____

ACCIDENT / INJURY / WORKER'S COMPENSATION

If you (the patient) are seeing the doctor because of an **accident**, please complete:

Date of accident/injury _____ Type of accident/injury _____

Is this a worker's compensation claim? ☐ Yes ☐ No

If yes, please provide the name, address, and telephone number of the worker's compensation insurance company:

_____

(CONTINUE ON OTHER SIDE)

PATIENT INFORMATION FORM

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I have read and understand the Capital Foot & Ankle Financial Policy form and I agree to its terms and conditions.

_____ _____

PATIENT (OR REPRESENTATIVE) SIGNATURE DATE

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Capital Foot & Ankle, P.C. to release any and all information from my medical record including information concerning medical and hospital records, and not exclusive of information regarding psychiatric or mental health treatment, tobacco, alcohol or drug abuse, cancer, AIDS/HIV related information, and other communicable disease related information for the completion and processing of all claims for services and treatments. I understand that my medical record contains information which includes, but is not limited to, any medical condition I have had in the past, now have, or may have in the future, presenting symptoms and complaints, any histories, findings on examination, medical treatment, hospitalization, bills, financial information, operative reports, lab test results, x-rays and reports, diagnostic tests and reports, consultative reports, daily progress reports or notes, and medications.

If my insurance benefits are provided to me through Medicare, I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other insurance" is indicated in item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

I understand that my medical record is confidential and that I may refuse authorization to disclose all or some of the information contained therein, but that refusal may result in denial of coverage or claim for health benefits or other insurance.

I release Capital Foot & Ankle, P.C. from any and all legal responsibility or liability that may arise from the act I authorized above.

_____ _____

PATIENT (OR REPRESENTATIVE) SIGNATURE DATE

ASSIGNMENT OF INSURANCE BENEFITS

I assign to Capital Foot & Ankle, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize direct payment of all such insurance benefits to Capital Foot & Ankle P.C., and agree to pay for any and all charges not paid pursuant to this agreement. If my insurance benefits are provided to me through Medicare, I hereby authorize and assign any and all reimbursement pertaining to said services to be made on my behalf and paid directly to Capital Foot & Ankle, P.C.. I authorize the use of this signature on all insurance submissions.

_____ _____

PATIENT (OR REPRESENTATIVE) SIGNATURE DATE