PATIENT ANNUAL UPDATE FORM

**PLEASE COMPLETE ALL INFORMATION*

DEMOGRAPHIC INFORMATION

NAME: First: _____ **MI:** _____ **Last:** _____

Date of Birth: _____ **Gender**: ☐ Male ☐ Female ☐ Undifferentiated

Ethnicity: _____ Preferred Language: _____

Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

EMAIL Address: _____

How do you prefer to be contacted? ☐ E-mail ☐ Mail ☐ Text ☐ Phone

☐ Retired ☐ Student ☐ Employed Employer: _____

Emergency Contact: _____ Emergency Phone #: _____

Relationship: _____

PRIMARY CARE INFORMATION

Primary Care Doctor (Who provides your health care): _____

Office #: _____ Date of the last visit: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Primary Card Holder: _____ Secondary Card Holder: _____

Card Holder DOB: _____ Card Holder DOB: _____

Member #: _____ Member #: _____

Group #: _____ Group #: _____

MISCELLANEOUS

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

- A demographic information update is required at the beginning of every year. Please have your insurance information and photo identification readily available at the time of check in, to allow us to process your demographic information update in a timely manner.

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.
   - If you have no insurance or you choose to be billed as Self-Pay, we will collect on any office visit and x-ray amounts upon arrival prior to being seen. Any remaining balance after being seen will be collected at check-out.

2. CO-PAYS, CO-INSURANCE and DEDUCTIBLES:
   - All Co-Pays, Deductibles, Co-insurance and any additional charges will be collected at the time of your visit. You are ultimately responsible for all payment of charges for services from our office.
   - Account balances must be paid in full at the time of today's appointment prior to seeing the doctor.
   - 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.
   - 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 balance and all future visits to our office must be paid via credit card or cash. We will no longer accept checks if there has ever been a returned check to our office for insufficient funds.
   - **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 $35.00 No-Show/No-Call Fee***. (We make reminder calls as a courtesy, but **it** is your responsibility to keep track of your appointment).
   - Repeat failure to keep your scheduled appointments may force us to have your medical care transferred elsewhere.

- If a patient has two consecutive No-Show/No-Call fees, the balance of $70 must be collected via credit card prior to scheduling another appointment in our office.
- If a patient is late on the day of an appointment, the office will do everything possible to see the patient in a timely manner. If the patient decides to not keep that day's appointment or reschedule the appointment a $35.00 fee will be applied to the patient chart for the missed appointment.
- A **$250.00** deposit is required at time of scheduling a surgery. Once all your insurance claims have processed and 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.**
   - All fees and account balances must be paid prior to 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 of request.**

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.
   - We do not accept returns of diabetic shoes or diabetic inserts for any reason. (See Authorization for Payment and Warranty form if dispensed diabetic shoes)
   - HIPAA and NC Health Regulations **prohibit** the **return** of previously dispensed products.

7. SUMMARY / STATEMENTS:
   - Your summary may not be ready for you at then end of your visit, due to the fact that our doctor must first chart your visit, which will be after he sees all of his patients for the day.
   - Statements are mailed out 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:_____