Ozark Foot & Ankle PLC

JAMES J. BRANTLEY, D.P.M., J.D.

PODIATRIC PHYSICIANS & SURGEONS

Patient Information THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS **Date:** _____ / _____ / _____

First Name: _____ **MI**:_____ **Last Name**:_____

DOB: _____ / _____ / _____ **Sex**: M / F **SSN**: _____ / _____ / _____

Race: ___American Indian or Alaskan Native ___Asian ___Black or African American
___Hispanic or Latino ___White ___Patient Declines
___Native Hawaiian or Other Pacific Islander

Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ___Patient Declines

Patient Address:_____

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

Marital Status:_____**Employer**:_____

May we call you at work? Yes NO Occupation:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Best Number to Reach You? _____ EMAIL: _____

May we confirm your scheduled appointments by email? YES NO

If the patient is a minor, please list the names of parents/legal guardians: Include address and phone number if different than above)_____

_____

Emergency Contact Name:_____ Phone:_____

Relationship:_____

Address:_____

How did you hear about our office?_____

Did anyone refer you to our office? If yes, name: _____

Who is your primary care doctor/provider (PCP)? _____

PCP's phone: _____ Location (town): _____

Insurance Information: Guarantor is the person whose NAME is on the card.

Primary Insurance Company: _____ Secondary Insurance Company: _____

Insurance ID Number: _____ Insurance ID Number: _____

Insurance Group #: _____ Insurance Group #: _____

Name of Guarantor: _____ Name of Guarantor: _____

Relationship to patient: _____ Relationship to patient: _____

Guarantor Social Security Number: _____ Guarantor Social Security Number: _____

Pharmacy Information: Pharmacy Name: _____

Address (Street & Town): _____ Pharmacy Phone: _____

JAMES J. BRANTLEY, D.P.M., J.D.

Treatment Authorization

I, the undersigned, give my permission to Dr. Brantley and/or his associate(s) to evaluate, administer treatment, and perform those procedures that **have been discussed and mutually agreed upon** as may be deemed necessary in the diagnosis and/or treatment of my lower extremity conditions.

_____

Name of patient (PRINTED)

_____ _____

Signature of patient: (parent/legal guardian **if patient is a minor**) Date:

AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

I, the undersigned, request medical/surgical services from Dr. Brantley and/or his associate(s). I understand that I am financially responsible to the above named physician(s) for all charges whether or not paid by my insurance and/or Medicare.

RELEASE INFORMATION: I, the undersigned, hereby authorize Dr. Brantley and/or his associate(s) to furnish information to insurance carriers regarding this illness necessary to process the claims for services rendered. I further authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information need to determine benefits payable for related services.

ASSIGNMENT OF BENEFITS: I, the undersigned, hereby authorize the payment of benefits for medical and/or surgical treatment directly to Dr. Brantley and/or his associate(s) including major medical benefits, otherwise payable to me, for this period of treatment. I, as the patient and/or responsible party, further agree to cooperate, and provide information as needed, wherever to assist in the prosecution of such claims for benefits upon request.

STATUTE OF LIMITATIONS: I, the undersigned, waive the right to claim any statute of limitations regarding billing CLAIMS for services rendered by or to be rendered by the physician(s) named above. In addition, I hereby authorize that in the event of default in the payment of any amount due, and if this account is placed in the hands of any agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection including agency and attorney fees and court costs incurred and permitted by laws governing these transactions.

A photocopy of this authorization shall serve as an original. This authorization shall remain in effect until revoked by the patient and/or insured in writing.

_____

Name of patient (PRINTED)

_____ _____

Signature of patient:
(parent/legal guardian **if patient is a minor**) Date

Financial Policy

TO ALL PATIENTS:

Thank you for choosing OZARK FOOT & ANKLE, PLC. We are committed to providing you with the best possible podiatric medical and surgical care at the lowest possible cost. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment:

- A copy of the patient's insurance card along with a valid photo ID is required in order to verify the identity of the patient and the insurance coverage so that claims may be processed accurately.
- Payment for all services provided by our practice is due in full at the time the services are rendered. Exceptions to this policy are those patients who are members of a managed care plan with which OZARK FOOT & ANKLE, PLC participates, Medicare, or Medicaid. Using the insurance information provided, we will calculate your payment due at time of service. Realizing that every claim is different, our calculations may not be exact. If a balance is due we will send a statement that is payable upon receipt and if a credit is due, we will issue a refund check.

VERIFICATION OF INSURANCE COVERAGE AND BENEFITS:

Our office will contact your primary insurance carrier to verify your coverage, benefits and any deductible remaining for the year prior to your visit. Co-payments, remaining deductibles, and co-insurance will be calculated and due at the time of the visit.

- If you are a member of a managed care plan with which OZARK FOOT & ANKLE, PLC participates, we will file the charges for your visit with your insurance. Your deductible, co-payment, and any co-insurance is expected at the time services are rendered.
- If OZARK FOOT & ANKLE, PLC does not have a contractual agreement with your insurance carrier, you are responsible for the full payment at the time services are rendered.
- Medicare patients are responsible for their co-payments, deductibles, any service deemed Medically Unnecessary or non-covered services or supplies. You are responsible for the full payment at the time services are rendered.
- You will be billed in full for any services that your health plan deems to be a non-covered service or any balances due after we have received payment from your insurance carrier. All patient balances are payable upon receipt of the statement.
- Disability Claims, Leave of Absence (FMLA) paperwork and any other forms you might ask our office to complete require a $25 (per set of forms) pre-payment and 72 hours to process. Paperwork needed in less than 72 hours will require a $50 pre-payment fee.
- OZARK FOOT & ANKLE, PLC accepts Cash, Personal Checks, MasterCard, Visa, and Care Credit
- A $25.00 Return Check Fee will be assessed to your account for every check returned to OZARK FOOT & ANKLE, PLC as non-payable.
- OZARK FOOT & ANKLE, PLC reserves the right to turn any patient over to collections if it is deemed that the account has been in default of the payment obligations or compliance of this policy. Patient will be responsible for any legal or court fees.

Cancellation / No Show policy

Our office makes several attempts to confirm your appointment prior to the scheduled date. If you are unable to keep an appointment, please give us a minimum of 24 hours -notice. There will be a $35 charge for all appointments that are not cancelled at least 24 hours prior to the set appointment time by calling our office at (479)582-1199 and speaking with one of our staff, our answering service or leaving a voice mail. The charge will need to be paid prior to rescheduling the appointment.

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communication. Thank you for understanding our Financial Policy. If you have any questions about financial arrangements, please feel free to speak with our practice management representative. We will make every effort available to you to clarify any misunderstanding you have concerning your account.

Financial Policy

By signing below I am confirming that I have read the Financial Policy, had the opportunity to ask questions, and fully understand the terms.

_____ _____ / _____ / _____

Signature Date

Notice of Privacy Practices:

By signing below I am confirming that I have been told that a copy of the "Notice of Privacy Practices" of Ozark Foot & Ankle, PLC is located in the front reception area. I understand that this folder is available at all times for my review. I understand that I may obtain a copy for my personal records if I request one from the front office receptionist.

_____ _____ / _____ / _____

Signature Date

Medication History

I authorize Ozark Foot & Ankle, PLC, Dr. Brantley, and/or his associates, or whomever he may designate as his assistant(s) to electronically request my prescription medication history. I understand that I may revoke this authorization any time at my election by doing so in writing and by delivering that written revocation to the clinical office of Ozark Foot & Ankle, PLC.

_____ _____ / _____ / _____

Signature Date

Information Release

I hereby authorize the release of my individually identifiable health information (protected health information or PHI) and medical information by Ozark Foot & Ankle, PLC to the following people:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

RX _____
DME _____
Referral _____
Other _____

CHIEF COMPLAINT

_____ _____
PATIENT NAME **DATE**

Please describe the foot/ankle/lower extremity problem you are having: _____

_____

Right foot/ankle or Left foot?

Please describe the exact location on the foot or ankle of the problem: _____

_____

Is the problem the result of an injury? YES NO If yes, please describe the injury: _____

_____

On a scale of 1-10, with 10 being the most severe, please rate how severe is the problem:
(Please circle one) 1 2 3 4 5 6 7 8 9 10

If painful, what does the pain feel like? (stabbing, throbbing, burning, dull, shooting, achy, etc.)_____

_____

How long has condition been present: _____

When is it present: _____

Describe what makes the condition worse: _____

_____

Describe what helps the condition: _____

_____

Please list any treatment you have had for the condition (by yourself or a health professional):

_____

PODIATRIC PHYSICIANS & SURGEONS

MEDICAL HISTORY

PATIENT NAME_____ **DATE:** _____ / _____ / _____

Please indicate whether you have recently experienced the following by circling either "**YES**" or "**NO**" for **every** item listed

Anemia	Yes	No	Anxiety		Yes	No	Arthritis		Yes	No	
Asthma	Yes	No	Back Problem	Yes	No		Breast Cancer	Yes	No		
Cancer	Yes	No	Cholesterol High	Yes	No		COPD	Yes	No		
Dementia	Yes	No	Depression	Yes	No		Dermatitis	Yes	No		
Diabetes	Yes	No	Epilepsy	Yes	No		Reflux (GERD)	Yes	No		
Glaucoma	Yes	No	Gout	Yes	No		Headache	Yes	No		
Hepatitis	Yes	No	HIV	Yes	No		Hypertension	Yes	No		
Migraine	Yes	No	Pneumonia	Yes	No		Kidney Stone	Yes	No		
Stroke	Yes	No	TB (Tuberculosis)	Yes	No		Thyroid	Yes	No		
Ulcer (GI)	Yes	No									
Benign Prostatic Hypertrophy (BPH)			Yes	No			Coronary Artery Disease (CAD)		Yes	No	
Congestive Heart Failure (CHF)			Yes	No			Heart Attack (MI)		Yes	No	

Please list any additional Medical Conditions/Problems you have ever had that are NOT included in the above-listed items:

____

____

____

SURGICAL HISTORY

_____ **I have No Surgical History**

I have had the following Surgical History:

Date of Surgery	**Surgical Procedure**	**Hospital/Surgery Center**	**Complications**

FAMILY HISTORY

Please list any medical conditions and/or diseases suffered by family members (e.g. Father – Heart Attack; Mother – Cancer):

Relation	Medical Condition	Alive/Deceased
_____	_____	
_____		

_____

PATIENT NAME_____ **DATE: _____ / _____ / _____**

ALLERGIES

____ I have NO Allergies.

____ I have the following allergies:

Allergic to _____; Symptoms _____; mild / moderate / severe

Allergic to _____; Symptoms _____; mild / moderate / severe

Allergic to _____; Symptoms _____; mild / moderate / severe

MEDICATIONS

Please list **ALL medications you are currently taking**, both PRESCIPTION and OVER-THE-COUNTER Medications. If you already have a list of medications please let us know and we can make a copy.

MEDICATION & DOSE MEDICATION & DOSE

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY

TOBACCO –Please indicate any use of tobacco, frequency and length of use.

____ Never Smoked ____ Former Smoker: Please give the date you quit_____/____/____

____ Current every day smoker: How many times have you tried to quit? _____

____ Cigarettes ____ packs per day Number of years ____
____ Cigars ____ per day Number of years ____
____ Pipe ____ times per day Number of years ____
____ Chewing tobacco ____ times per day Number of years ____
____ Dipping Tobacco ____ times per day Number of years ____

ALCOHOL-Please indicate type, quantity, and frequency of alcohol consumption.

____ Do not consume alcohol
____ Beer quantity _____ how often _____
____ Wine quantity _____ how often _____
____ Hard Liquor quantity _____ how often _____

Describe any prior treatment/counseling for overuse of alcohol: _____

REVIEW OF SYSTEMS

PATIENT NAME_____ **DATE: _____ / _____ / _____**

Please mark any of the following that you have **recently** experienced with an "**X**" in the space provided. Any condition NOT marked will be recorded as "NO" (not experienced) in your medical record.

Constitutional
__Chills
__Fatigue
__Fever
__Weakness
__Weight Gain
__Weight Loss

Ears
__Hearing Aid

Mouth
__Bleeding
__Dentures
__Dry Mouth
__Post Nasal Drip
__Cramps in Legs/Feet

Respiratory
__Asthma
__Bronchitis
__COPD
__Cough
__Pluerisy
__Short of Breath
__TB__Palpations
__ Wheezing
__Rheumatic Fever

Muskuloskeletal
__ Ankle Sprain
__Arch Pain
__Arthritis
__ Back Problems
__Broken Ankle
__Broken Foot Bone
__Bunions
__Calluses
__Childhood Foot Problems
__Corns
__Flat Feet
__ Gait Walking Problems
__Gout
__Hammer/Mallet Toes
__Heel Pain
__High Arch Foot
__In-Toeing
__ Joint Implants
__ Joint Pain
__Joint Stiffness
__Knee Pain
__ Lower Back Pain
__Muscle Cramps
__Muscle Stiffness
__Neuroma
__Orthotic Use
__Paralysis
__Restricted Motion
__ Shoe Insert Use
__Toe Walking
__ Weakness

Head
__Dizziness
__Fainting
__Headaches
__Pain
__Sweats

__Hoarseness
__ Lumps

__Infections
__Ringing

Cardiovascular
__Chest Pain

__Constipation
__Extremity(s) Cool
__Hair Loss on Legs
__Heart Murmur
__High Blood Pressure
__History of Heart Attack
__Leg or Foot Ulcers
__Lower Extremity Swelling

__Laxatives
__ Replacement Heart Valve

__Nausea
__Varicose Veins
__Vascular Grafts

Psychiatric
__Depression
__Disorientation
__Memory Loss

Neurologic
__Black-Outs
__Burning Sensation
__Charcot Neuropathy
__Fainting
__Neuromas
__Numbness
__Speech Disorder
__Stroke
__Tingling
__ Tremors
__ Unsteady Gait

Nose
__Bleeding
__Discharge
__Infection
__Obstruction

Throat/Neck

Urinary
__Sore Throat
__Tenderness

Gastrointestinal
__Antacid Use
__Infections
__Diarrhea
__Excessive Thirst
__Gall Bladder Disease
__Heart Burn
__Hemorrhoids
__Hepatitis
__Jaundice
__Blood Clots
__ Liver Disease
__Recent Chemotherapy
__Rectal Bleeding
__Swallowing Problems
__Vomiting

Skin
__Athlete's Foot
__Dryness
__Eczema
__Fungal Nails
__Hives
__Ingrown Nails
__Itching
__Keloid Scar
__Lumps
__ Mole Changes
__Rash
__Ulcers
__Warts

Endocrine
__Fatigue
__Goiter
__Sweats
__ Thirst
__Thyroid Disorder
__Weight Gain
__Weight Loss

Female Reproductive
__Birth Control
__Hernia
__Menopause
__Pain
__Recent Pregnancy
__Venereal Disease

__Blood in Urine
__Burning
__Excessive Urination
__Flank Pain
__Incontinence

__Kidney Stones
__Retention
__Urgency

Hematologic/Lymphatic
__Anemia
__Bleed Easily

__Easy Bruising

__Slow Healing of Cuts
__Swollen Glands
__Transfusion Reaction

Eyes
__Blurred Vision
__Cataracts
__Contacts
__Eye Glasses
__Glaucoma

Male Reproductive__NA
__Hernia
__Pain
__Prostate Problems
__Venereal Disease

Allergic/Immunologic
__Hives
__Itchy Eyes
__Itchy Nose
__Runny Nose
__ Sneezing
__Stuffy Nose
__ Swelling
__Watery Eyes
__Wheezing

Other condition NOT listed: _____