3011 S. Lindsay Road Suite 113
Gilbert, AZ 85295

Telephone: 480-759-6737
Fax: 480-759-5404

Gregory P. Rowe DPM, P.L.C.

Patient Information

Today's Date: _____
Patient's Name: _____ Sex: Male _____ Female_____
Date of Birth: _____ Age: _____ Social Security #:_____
Address: _____
(Street) (City) (State) (Zip Code)
Please Also Circle Preferred Use of Contact:
Home Phone:_____ Cell Phone:_____ Work Phone: _____
Email Address:_____
Patient's Employer: _____
Preferred Pharmacy:_____
Sports/Physical Activity: _____

Responsible Party Information

(If self leave blank)

Responsible Party's Name: _____ Sex: Male_____ Female_____
Date of Birth: _____ Age: _____ Social Security #:_____
Address: _____
(Street) (City) (State) (Zip Code)
Home Phone:_____ Cell Phone:_____
Patient's Employer:_____ Work Phone: _____

Insurance Information

Primary Insurance Name:	Secondary Insurance Name:
Policy Holder: DOB:	Policy Holder: DOB:
ID #: Group #:	ID #: Group #:
Employer:	Employer:

Is this a work related injury? Y or N. If Yes, Date of injury:_____ Carrier:_____
Claim #:_____Adjustor: _____ Phone #:_____

Emergency Contact: _____ Relation: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____
How did you hear about us? (Please Circle)

Primary Care Physician Family/Friend Insurance Our website/Facebook/Yelp/Google

Other: _____

Assignment of Benefits: I authorize the release of information necessary to process this claim and hereby assign my insurance benefits be paid directly to Gregory P. Rowe DPM and Gregory P. Rowe, DPM, P.L.C. I acknowledge financial responsibility for services, which are not covered by my insurance company.
Signature: _____ Date: _____

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Podiatric History

Chief Complaint: (Circle and fill in the blank)

What is the nature of your pain? Sharp Dull Achy Throbbing Tingling Shooting

Where is your pain located? _____

How long ago did your pain start? _____

Did your pain come on suddenly or gradually? _____

Is your pain getting: Better Worse Staying the Same

What makes your pain better? _____

What makes your pain worse? _____

Review of Systems: (Circle all that apply)

Constitutional:

Chills Fever Weight loss Decline in Health Weakness Fatigue Weight gain

Cardiovascular:

Chest pain Hair loss on legs High Blood Pressure Swelling of legs Varicose Veins

Extremities Cool Extremities Discolored Leg Pain Walking Ulcers on legs

Skin:

Dryness Itching Nail Appearance changes Skin Color changes Eczema Rashes

Neurological:

Tingling Burning Numbness Unsteady Gait

Musculoskeletal:

Arthritis Gout Muscle Cramps Restricted Motion Joint Pain

Back Pain Deformities Joint Stiffness

Allergies:

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Medications:

Family Hx:

Medical Hx: (Circle All That Apply)

Anemia	Anxiety	Arthritis	Asthma
BPH	Back Problems	Breast CA	CAD
CHF	COPD	Cancer	Cholesterol High
Dementia	Depression	Dermatitis	Diabetes
Epilepsy	GERD	Glaucoma	Gout
HIV	Headache	Hepatitis	Hypertension
MI	Migrane	Pneumonia	Renal Stone
Stroke	TB	Thyroid Ds	Ulcer (GI)

Social Hx: (Circle and Fill in the Blank)

Tobacco:

Current: Daily usage _____ pack/day, # of yrs _____
Former: Last used _____
Never smoked

Alcohol: (Please Circle)

Beer:	Social	Occasional	Light	Heavy
Wine:	Social	Occasional	Light	Heavy
Hard Liquor:	Social	Occasional	Light	Heavy

No alcohol Hx

Surgical Hx:

Height: _____ ft _____inches

Weight: _____lbs

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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 understood the Notice.

_____ _____
Patient Name (Please Print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

I authorize the release of medical information / test results to the following person(s) other than myself.

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I authorize AACI Foot and Ankle Care Centers to leave information / test results on my voice mail and / or answering machine at the following contact numbers.

Home: _____ Cell: _____ Work: _____

_____ _____
Signature Date

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Patient Financial Obligation Agreement

- I / WE, THE UNDERSIGNED, AUTHORIZE THE DOCTOR(S) AND STAFF OF THE MEDICAL PRACTICE LISTED ABOVE TO TREAT THE PATIENT NAMED ON THIS FORM AND AGREE TO PAY ALL FEES AND CHARGES FOR SUCH TREATMENT.
- I / WE AGREE TO PAY ALL CHARGES FOR MYSELF AND MEMBERS OF MY FAMILY PER THE TERMS OF THIS AGREEMENT. CHARGES SHOWN ON THE BILLING STATEMENTS ARE AGREED TO BE CORRECT AND REASONABLE UNLESS DISPUTED IN WRITING WITHIN 30 DAYS OF THE BILLING DATE.
- I / WE ACKNOWLEDGE THAT SHOULD ANY BALANCE REMAIN UNPAID BY MY HEALTHCARE PLAN AFTER 90 DAYS FROM THE DATE THAT SERVICES WERE PROVIDED, THE ENTIRE BALANCE WILL BE BILLED TO ME. IF ANY PATIENT BALANCE IS NOT PAID IN FULL WITHIN 30 DAYS OF THE ORIGINAL PATIENT STATEMENT DATE, THE ENTIRE BALANCE WILL BE SUBJECT TO A 1.5% MONTHLY SERVICE CHARGE.
- I / WE AGREE THAT IN THE EVENT THAT LEGAL ACTION BECOMES NECESSARY TO COLLECT AN UNPAID BALANCE DUE FOR SERVICES RENDERED TO ME OR MY LEGAL CHARGE, I AM RESPONSIBLE FOR ANY AND ALL ATTORNEY'S FEES AND COURT COSTS INCURRED BY THE ABOVE MENTIONED MEDICAL PRACTICE OR ITS' REPRESENTATIVES.
- I /WE AGREE THAT PAYMENTS WILL NOT BE DELAYED OR WITHHELD, REGARDLESS OF TREATMENT OUTCOME, LAWSUITS, LIENS, OR INSURANCE COVERAGE OR THE PENDANCY OF CLAIMS THEREON. IT IS ALSO AGREED THAT ALL PROCEEDS OF INSURANCE OR MEDICAL BENEFITS PROGRAM(S) ARE ASSIGNED TO THIS MEDICAL PRACTICE WHERE APPLICABLE. I / WE UNDERSTAND THAT I AM RESPONSIBLE FOR PAYING ALL DEDUCTIBLES, CO-PAYMENTS, NON-COVERED SERVICES, AND ANY PORTION OF COVERED SERVICES NOT PAID IN FULL BY MY / OUR INSURANCE OR GOVERNMENT BENEFITS PROGRAM. SUCH PAYMENTS ARE DUE AT THE TIME OF SERVICE OR IMMEDIATELY UPON PRESENTATION OF THE BILL.
- I / WE AGREE THAT WE SHALL REMAIN FINANCIALLY RESPONSIBLE FOR THE ABOVE NAMED PATIENT UNTIL I NOTIFY YOU IN WRITING AS TO THE CONTRARY. THIS GUARANTEE IS CONTINUING EVEN IF THE ACTUAL PATIENT, IF A MINOR, REACHES THE AGE OF MATURITY.
- I / WE AUTHORIZE THE ABOVE LISTED MEDICAL PRACTICE AND ITS' AGENT(S) TO CONTACT MY INSURANCE PROVIDER AND THE EMPLOYER OF THE POLICY HOLDER TO VERIFY MY ELIGIBILITY FOR INSURANCE COVERAGE. I AUTHORIZE EXCHANGE OF MEDICAL, BILLING, AND COLLECTION INFORMATION WITH THE HEALTH CARE FINANCE ADMINISTRATION AND THEIR AGENT(S), MY / OUR INSURANCE COMPANY, AND ANY OTHER HOLDER OF INFORMATION NECESSARY TO OBTAIN PAYMENT FOR SERVICES RENDERED. IN ADDITION, I / WE AUTHORIZE YOU OR YOUR AGENT TO EXCHANGE PAST, PRESENT, AND FUTURE MEDICAL INFORMATION WITH THE PATIENT'S OTHER HEALTH CARE PROVIDERS IN ORDER TO ENHANCE AND PROMOTE THE CONTINUITY OF CARE FOR THE PATIENT.
- I / WE HEREBY NAME AS ASSIGNEE AND ALSO INSTRUCT AND DIRECT ANY AND ALL OF MY / OUR INSURANCE COMPANY AND / OR GOVERNMENT BENEFITS PAYER TO PAY BY CHECK(S) MADE OUT AND MAILED TO THE ASSIGNEE :
- **ALL PATIENTS MUST HAVE A BALANCE OF $200 OR LESS TO BE SEEN IN THE OFFICE, UNLESS AUTHORIZED BY DR. Rowe.**

Gregory P. Rowe, D.P.M.
3011 SOUTH LINDSAY ROAD SUITE 113 GILBERT, AZ 85295

- IF MY POLICY PROHIBITS DIRECT PAYMENT TO PROVIDERS, I / WE HEREBY INSTRUCT AND DIRECT THE INSURANCE COMPANY TO ASSIGN THE CHECK TO ME AND MAIL TO THE ADDRESS HIGHLIGHTED ABOVE. FURTHERMORE, I / WE GRANT LIMITED POWER OF ATTORNEY TO SIGN MY / OUR NAME, DEPOSIT, AND NEGOTIATE ANY INSURANCE PAYMENT RECEIVED, AND APPLY IT TO MY / OUR OUTSTANDING BALANCE. I / WE AGREE TO PAY ANY REMAINING BALANCE AFTER INSURANCE REIMBURSEMENT IMMEDIATELY UPON NOTIFICATION. ANY INSURANCE PAYMENTS RECEIVED BY ME FOR ANY UNPAID BALANCE WILL BE IMMEDIATELY ENDORSED TO THE MEDICAL PRACTICE LISTED ABOVE. FAILURE TO DO SO MAY RESULT IN A SERVICE CHARGE OF 1.5% MONTHLY.
- I / WE AGREE THAT A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL AND THAT THIS ASSIGNMENT SHALL REMAIN IN EFFECT UNTIL CANCELED IN WRITING BY THE ASSIGNEE.
- THIS INSTRUMENT CONTAINS THE ENTIRE AND ONLY AGREEMENT BETWEEN THE PARTIES AND THERE ARE NO OTHER PROMISES, REPRESENTATIONS, OR WARRANTIES, EITHER EXPRESSED OR IMPLIED. THE PROVISIONS OF THIS AGREEMENT SHALL NOT BE CHANGED OR MODIFIED EXCEPT FOR AN INSTRUMENT, IN WRITING, SIGNED BY THE PARTIES HERETO.

THERE WILL BE A CHARGE OF $50.00 FOR FILLING OUT DISABILITY, FMLA & SHORT-TERM DISABILITY FORMS - DUE AT THE TIME OF EACH SERVICE.

THIS IS A DIRECT ASSIGNMENT OF MY / OUR RIGHTS AND BENEFITS UNDER THIS POLICY.

I / WE HAVE READ COMPLETELY AND UNDERSTAND THE STIPULATIONS AND AGREEMENTS LISTED IN THE DOCUMENT ABOVE AND AGREE TO ABIDE BY ALL.

Print Patient Name_____

Signature_____ Date_____

Relationship to Patient _____

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Notice of Privacy Practices

To Our Patients:

This notice describes how health information about you (as a patient of AACI Foot, Leg and Ankle care) May be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

Our Commitment to your Privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following information:

Use and disclosure of your health information in certain special circumstances:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.

3. If required to do so by a law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.

5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

8. For Workers Compensation and similar programs.

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Your rights regarding your health information:

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than at work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to (AACI Foot, Leg and Ankle care, Gregory P. Rowe, Privacy officer, 3011 South Lindsay Rd, #113, Gilbert, AZ 85295).

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to (AACI Foot, Leg and Ankle care, Gregory P. Rowe, Privacy officer, 3011 South Lindsay Rd, #113, Gilbert, AZ 85295). You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint either directly with the practice, or to the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact (Gregory P. Rowe, DPM, or our privacy officer). All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If a disclosure of your protected health information was made for a reason other than treatment, payment or health care operations, you have a right to receive an accounting of the disclosures.

If you have any questions regarding this notice or our health information privacy policies, please contact AACI Foot, Leg and Ankle care at 480-759-6737 for further questions.

I, as the Patient and/or Guardian, have read and understand all the information, as written in the English language, in the above documents given to me by the provider.

Print Patient Name _____
Signature _____ Date _____
Relationship to Patient _____