Date: ________________

Twin Cities Foot & Ankle Clinic, P.A.

Account #: ___________________________

Please use Black Ink

Patient Information

Patient Name (Legal Name) First | Middle Initial | Last | Name you prefer to be called

Birth Date | Age | Sex M F | Email address

Home Address | Street | Apt. # | City | State | Zip Code

Home Phone ( ) | Work Phone ( ) Ext. | Cell Phone ( ) | Preferred Communication (circle 1) Home Cell Work

Occupation | Primary Language Spoken:

Race / Ethnicity (check any and all that apply)
☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic or Latino
☐ Black or African American ☐ White ☐ Some Other Race
☐ Native Hawaiian/Other Pacific Islander ☐ Unknown

Employer | How Long There?

Preferred Pharmacy | **Address** | **City** | **State** | **Phone**

Friend or Relative for Emergency Contact

Name | Relationship

Home Phone ( ) | Work Phone ( ) | Cell Phone ( )

Physician Information

Primary Care Physician | Clinic Name | Clinic Phone Number

When did you last see your primary doctor?

Referring Physician (if different from Primary Physician) | Clinic Name | Clinic Phone Number

How Were You Referred To Our Office? ☐ Internet ☐ Insurance/Nurseline/Hospital ☐ Saw The Sign ☐ Angie's List
☐ Twin Cities Marathon ☐ Referred By Doctor (Name:________________________) ☐ Television
☐ Friend/Relative (Name:________________________) ☐ Other (________________________)

Insurance Information - Bring insurance card(s) to every appointment.

Primary Insurance Company

Policyholder Name | **Policyholder DOB**

Secondary Insurance Company

Policyholder Name | **Policyholder DOB**

SEE BACK SIDE OF FORM

Release of Medical Information:

If you would like us to be able to give medical information to somone other than yourself, please complete the following authorization. I authorize the physicians and staff of Twin Cities Foot & Ankle Clinic, P.A. to communicate with the following persons regarding my medical care:

Printed Names of Family Member/Legal Representative/Other Specified Person	**Relationship (Spouse/Significant Other/Parent/ Other Specified Person)**
______________________________	______________________________
______________________________	______________________________

If a name is not provided, Medical information will not be released to personal representatives.

Telephone communication/authorization to release information: I authorize Twin Cities Foot & Ankle Clinic, P.A. to leave the following information (check all that apply) to be left on my home / work / cell:
(circle)

___ Scheduling of Appointments/Procedures ___ Medical Information ___ Billing Information

I understand this authorization will be valid until revoked in writing.

__________ **I am aware of the Twin Cities Foot & Ankle Clinic, P.A. Financial / No Show Policy. There is a $25.00 fee for no-show appointments.**
Initial

Release of Medical Records, Medical Information and Assignment of Insurance Benefits:

I, the undersigned patient and/or responsible party hereby jointly authorize this office, its agent and employees, to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable for all or part of the provider's charges. I authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.

I authorize the release and disclosure, via fax machine, of any and all of my medical records to any other entity including but not limited to, referring physicians, hospitals, or health care providers which may be of assistance, in the opinion of this office, in the providing for the treatment of the patient.

I request and authorize that payment of Medicare/other insurance company benefits be made to Twin Cities Foot & Ankle Clinic, P.A. for any services furnished me by a provider of our clinic. The signature below shall suffice for all insurance forms on a continuing basis.

I understand that I am responsible for complying with the rules and regulations of my insurance company regarding Referral and Prior Authorization requirements. I agree to pay Twin Cities Foot & Ankle Clinic, P.A. for all charges for services not covered by Medicare or any insurance payer.

Signed: ______________________________ Date: ____________________

Notice of Privacy Practices

I acknowledge that I have been given the opportunity to review and/or receive a copy of the information contained in the Notice of Privacy Practices for Twin Cities Foot & Ankle Clinic, P.A.

______________________________ Date: ____________________
Signature of Patient or Legal Representative