CANYON
FOOT AND ANKLE

Patient Registration History

PATIENT INFORMATION

Date_____

_____
Last Name

_____
First Name Middle Initial

Date of Birth _____

SS#_____

Cell Phone

(_____) _____

Home Phone
(_____)_____

Work Phone
(_____)_____

Email _____

Address

_____

City

_____

State_____ Zip _____

Sex ☐ M ☐ F Age _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

How did you hear about us?_____

_____

Emergency Contact

Name _____

Relation to patient _____

Phone_____

2. INSURANCE

Primary Insurance _____

ID #_____

Subscriber's Name_____

Birthdate _____

SS# _____

Relationship to Patient_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Secondary Insurance _____

ID #_____

Subscriber's Name_____

Birthdate _____

SS# _____

Relationship to Patient_____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage as listed above, and assign directly to Canyon Foot & Ankle all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for *all* charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Canyon Foot & Ankle may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me, or on my behalf to Canyon Foot & Ankle, for any services furnished to me by them.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine their benefits for related services.

_____
Signature of Patient, Guardian or Personal Representative

_____
Please print name of Patient, Guardian or Personal Representative

_____
Date Relationship to Patient

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5. MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Eye Problems	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Artificial Heart Valves or Joints	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Hepatitis or Jaundice	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tired Feet	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Neuropathy	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Ear Problems	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No

Surgeries you have had _____

Hospitalization other than for surgeries listed _____

Family Physician _____ Last visit date _____ Height_____ Weight_____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No BP_____

If yes, please explain _____

Why did you come in today? How long has this been a problem? Which course of treatment has been tried so far?

_____

_____

Smoking History: Current Avg. _____ Past _____ Never _____

6. MEDICATIONS

Include prescriptions, over-the-counter medications, vitamins AND dose:

_____

_____

Pharmacy Name(s) _____

Do you take oral contraceptives? ☐ Yes ☐ No

7. ALLERGIES

☐ NONE	☐ Iodine
☐ Adhesive/Tape	☐ Local Anesthetics
☐ Anticoagulant Therapy	☐ Novocaine
☐ Aspirin	☐ Penicillin
☐ Codeine	☐ Seafoods
☐ Demerol	☐ Sulfa
☐ Other _____	

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Guardian or Personal Representative — Relationship to Patient

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PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING:

A) I agree that I am responsible for this debt regardless of my insurance and that I will pay any unpaid balance, in full, within 90 days of the date of billing. I agree to pay 18% interest per annum on the unpaid balance, compounded daily.

B) In the event that my account is not paid as agreed, I agree to pay a collection agency fee of 40% of my unpaid balance in addition to my balance, in the event that my account is delinquent.

C) In the event that it is necessary to commence legal action to collect this bill, I agree to pay reasonable attorney's fees and costs of court and agree to submit to the jurisdiction of the Third Circuit Court, Salt Lake City, State of Utah.

D) If any portions of a bill for the provider's services are disputed, I agree to submit my self to mediation or arbitration and will pay the costs incurred in doing so.

Signature:_____ **Date:**_____

HIPAA: NOTICE OF PRIVACY POLICY

Effective: March 2015

The following is the privacy policy of Canyon Foot and Ankle LLC ("Covered "Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Consent to the Use and Disclosure of Health Information

In accordance to the statements above, I understand that this information applies to:

My care and treatment plan

Communication among health professionals who contribute to my care

Application of my diagnosis and services, procedures, and surgical information to my bill

Verification of services billed by third-party payers

Quality of care and review of the competence of health care professionals in routine health care operations

I understand the following information about the privacy practices of Canyon Foot and Ankle LLC:

I have the right to review the notice prior to signing this consent

The organization reserves the right to change its notice and practices

Any revised notice will be mailed to the address I have provided

I have the right to object to the use of my health information for directory purposes

I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care options

The organization is not required to agree to the restrictions requested

I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Please list any other person(s) that you would allow to have access to your information:

_____ Relationship to Patient: _____

Patient Name:_____ Date of Birth:_____

_____

(Patient/Guardian Signature) **Date**