Yeager Foot and Ankle Center

Patient Registration

Today's Date_____

Patient Information (Please use full legal name)

Last Name _____First Name_____ Middle Initial:_____

Date of Birth _____ Social Security: _____ Nickname (Name I preferred to be called)_____

Gender : ☐ male ☐ Female Martial Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced

Physical Address_____ City_____ Zip code_____

Mailing Address_____ City_____ Zip code_____

☐Please mark box if the same as physical address

Email Address _____ Occupation:_____

Home Phone # _____ Mobile Phone # _____

Occupation _____ Work Phone #_____

Primary Care Physician _____ Date Last Seen: _____

Address:_____ City:_____ Zip Code:_____

Phone # _____

Preferred Pharmacy _____ Phone # _____

Do you currently have an active Workers Comp case?_____

Activities/Hobbies _____

Is there a caregiver needed for the patient?_____ Is transportation needed for the patient _____

Emergency Contact_____ Relationship to Patient_____ Contact #_____

Billing Information

Name of person responsible for this bill_____

Date of Birth _____ Social Security _____ Relationship to Patient_____

Occupation_____ Employer_____

Primary insurance Company_____ Subscriber Name _____

ID # _____ Group #_____ Policy # _____ Effective Date_____

Secondary insurance Company_____ Subscriber Name

_____

ID # _____ Group #_____ Policy # _____ Effective Date_____

Yeager Foot and Ankle Center

Last Name _____ First Name _____ Middle Initial: _____

Date of Birth _____ Age _____ Height _____ Weight _____ Shoe Size _____

Is your foot narrow or wide? _____ Have you purchased or been issued a DME product in the past 5 years? Yes/ No

Reason for Visit: _____

_____

_____

Duration: _____ ☐ Days ☐ Weeks ☐ Months ☐ Years
Onset: ☐ Sudden ☐ Gradual
Course: ☐ Improved ☐ Worsened ☐ No Change
Nature: ☐ Numbness ☐ Burning ☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing ☐ Pressure

Time of Day _____ ◯ Right Foot ◯ Left Foot ◯ Both Feet Location _____

Improves with _____ Worsens with _____

Past Treatment: ☐ Insole ☐ Brace ☐ Injection

OTHERS _____

PAST FOOT/ ANKLE PROBLEM _____

_____

_____

STAFF ONLY

1. _____

_____

2. _____

_____

3. _____

_____

Yeager Foot and Ankle Center

Last Name _____ First Name _____ Middle Initial: _____

Date of Birth _____

List of Current Medications _____

_____

_____

Allergies: ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Darvocet ☐ Aspirin ☐ Adhesive/Tape ☐ Ibuprofen
☐ Local Anesthetic (Lidocaine, Marcaine) ☐ OTHERS PLEASE LIST _____

General Health

- ◯ Anemia
- ◯ Arthritis
- ◯ Artificial Joint/ Implants
- ◯ Atherosclerosis
- ◯ Bleeding Disorder
- ◯ Blood Pressure: High / Low
- ◯ Cancer: Type_____
- ◯ Dementia/Cognitive impairment
- ◯ Diabetes: Insulin Yes/ No Years:_____
- ◯ Gout
- ◯ Heart Disease
- ◯ Heart Valve: Implants/ Disease
- ◯ Hepatitis: A/ B/ C
- ◯ History of Infection
- ◯ Hormones Problem
- ◯ Kidney Problems
- ◯ Liver Disease
- ◯ Lung Disease/ Asthma
- ◯ Neurological Disease
- ◯ Neuropathy
- ◯ Psoriasis
- ◯ Rheumatic Fever
- ◯ Rheumatoid Arthritis
- ◯ Stroke
- ◯ Thyroid Problem
- ◯ Ulcer (Stomach)
- ◯ Unexplained Weight
- ◯ Vascular (Circulation)

Family History

- ◯ Arthritis
- ◯ Bleeding Disorder
- ◯ Blood Pressure: High/ Low
- ◯ Bunion
- ◯ Cancer: Type_____
- ◯ Diabetes: Insulin Yes/ No
- ◯ Heart Disease
- ◯ HIV Positive/ Aids
- ◯ Neurological Disease
- ◯ Vascular (Circulation)

Social History

Tobacco use: Yes/ No
How often:_____

Alcohol use: Yes/ No
How often:_____

Drug use: Yes/ No
How often:_____

Disabilities

Is there a Wheelchair, walker, or cane needed to ambulate?
Yes/ No

Do you need information for assistance in your home? Yes/No

Surgeries/ Hospitalization

Date:_____
Procedure:_____
_____
_____
_____
Anesthesia (Type):
_____

Date:_____
Procedure:_____
_____
_____
_____
Anesthesia (Type):
_____

I understand that completing this paperwork I have provided is true to the best of my knowledge. I recognized that the information I have provided will help me receive better care.

Patient/Authorized Representative (if applicable)_____ Date_____

Yeager Foot and Ankle Center

Appointment Cancellation/ No Show Policy

Our goal is to provide quality individual medical care in a timely manner. "No show" and late cancellations inconvenience those individuals who need medical treatment.

As a courtesy, you will receive an automated call, email or text message two (2) days in advance to confirm your appointment. We will leave a message on a voicemail if you are unable to be reached. If you are not able to keep your appointment, we will be happy to reschedule it for you.

Please give us a 24 – hour notice to cancel or reschedule your appointment. Appointments are in high demand, and your early cancellation will give another person the possibility to received medical care in a timely manner.

Failure to give a 24-hour cancellation or being a no show will result in a nonrefundable charge of $50.00. This fee will not be covered by insurance. You will receive a paper notice in the mail from our clinic to let you know that you have a no show charge.

If you have any questions regarding the policy, please ask our staff and we will gladly clarify your questions. We thank you in advance for your cooperation and understanding.

Financial Policy

We will bill Medicare and/or your private insurance for you. We are not a Medi-Cal provider. You are responsible for the deductible, co-insurance and non-covered services. We appreciate payment in full at each visit unless we are billing your insurance for you. In this case, the balance is due immediately following your statement. If your carrier has not paid within a reasonable period after the billing, you are responsible for payment in full. We are happy to discuss a payment/financial plan with you if you feel you are unable to make payment in full.

Insurance Authorization

I hereby give authorization for payments of insurance benefits to be made to Yeager Foot and Ankle Center and any assisting physicians, for the services rendered. I understand that I am financially responsible for all charges whether they are covered by insurance or not. I understand my signature requests that payment be made and authorize release of medical information if necessary to secure the payment of benefits. In the event of default, I agree to pay all costs of collection. I further agree that a photocopy of this agreement shall be as valid as the original.

By signing, I have read and acknowledge the Cancellation/ No Show Policy, Financial Responsibility and Insurance Authorization.

_____ _____

Patient Name (signature) Date

_____

Patient or Authorized Representative (if applicable)

Yeager Foot and Ankle Center

Peripheral Arterial Disease (PAD) Questionnaire

Patient Information (Please use full legal name) **Today's Date:**_____

Last Name _____First Name_____Middle Initial_____

Date of Birth _____ Age_____ Gender_____

Answers to the following will help determine if you are at risk for PAD and it a vascular examination can help better assess your vascular health status.

1. Do you experience any pain in your legs or feet while at rest?	◯ Yes ◯ No
2. Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hip or thigh during walking/ exercising?	◯ Yes ◯ No
If yes to question 2, does the pain go away when you stop walking/ exercise?	◯ Yes ◯ No
3. Do your feet get pale, discolored or blush at any time during the day?	◯ Yes ◯ No
4. Do you have an infection, skin wound or ulcer on your leg or foot that is slow to heal over the past 8-12 weeks?	◯ Yes ◯ No
5. Do you have high cholesterol or other blood lipid (fat) problems or require cholesterol medication?	◯ Yes ◯ No
6. Do you have high blood pressure or take medication to reduce blood pressure?	◯ Yes ◯ No
7. Do you have Diabetes?	◯ Yes ◯ No
8. Do you have a history of chronic kidney disease?	◯ Yes ◯ No
9. Do you currently or have you ever smoked?	◯ Yes ◯ No
10. Do you have a history of stroke or mini stroke (TIA)?	◯ Yes ◯ No
11. Do you have a history of heart disease (heart attack, MI)?	◯ Yes ◯ No
12. Do you have a history of carotid stenosis, AAA (abdominal aortic aneurysm) and/or stent placement?	◯ Yes ◯ No

Patients and Care Team Partnership Agreement

Yeager Foot and Ankle Center has a strong tradition of excellence in patient care. We are committed to providing patient and family centered care along with the patient's participation. These expectations outline our partnership agreement which intended to provide compassionate care in an environment that promotes comfort, healing, and mutual respect between the patient and Care Team.

Expectations of the Patient and Care Team Partnership Agreement:

- Patient and Care Team (doctors, nurses, medical assistants, management, receptionist, etc.) will work together to provide the best possible care for the patient's progress during each visit.
- Patient will participate in cares necessary to encourage safe and timely discharge.
- Any rude, threatening, demanding comments or behaviors will be called out by the Care Team to the management team. Care will be terminated temporarily if the Care Team Member feels uncomfortable. Care will resume when respectful behavior is observed, and respectful communication is used. The Care Team will ask management to intervene if negative behaviors continue after request have been made to stop.
- Any physically threatening behavior demonstrated by the Patient will results in the intermediate termination of care.
- Families are welcomed and recognized as an important part of the patient's recovery. However, Yeager Foot and Ankle Center will not tolerate profanity, disruptive behavior, or any behavior that interferes with the care of any patient.
- Yeager foot and ankle center has a zero tolerance for any alcohol or drug use on the clinic property, abusive actions or language, or any other behavior that creates risk or threat to the patients, families, visitors, or the Care Team. Anyone, including families, violating our Zero Tolerance policy will be asked to leave the premises.

_____ _____

Patients Signature Date

_____ _____

Care Team Member Date

Yeager Foot and Ankle Center

429 REDCLIFF DR

SUITE 100

REDDING CA 96002

P. 530-244-0674 F. 530-244-1033

NEUROPATHY QUESTIONNAIRE

(Please circle YES or NO)

Does your pain have one or more of the following characteristics?

1. Burning YES or NO
2. Painful cold YES or NO
3. Electric Shocks YES or NO

Is the pain associated with one or more of the following symptoms in the same area?

1. Tingling YES or NO
2. Pins & Needles YES or NO
3. Numbness YES or NO
4. Itching YES or NO

Have you ever been Diagnosed with Neuropathy before?

YES or NO

Are you Diabetic?

YES or NO

Patient Name (Print) _____ Date _____

YEAGER FOOT AND ANKLE CENTER

429 REDCLIFF DR SUITE 100

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Payment Policy

Thank you for choosing Yeager Foot and Ankle Center to provide you with all your Podiatry needs. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibilities for serviced rendered here at Yeager Foot and Ankle Center, we have been advised to develop this payment policy. Please read this policy and feel free to ask us any questions that you may have and sign in the space provided on the second page. A copy will be provided upon request.

1. **Insurance.** We participate in most insurance plans including but not limited to Medicare, BlueShield, Aetna, Cigna, and Tricare. We are **NOT in network with BlueCross or Anthem. Unless you have Medicare as primary insurance.** If you are not insured by a plan that we are not contracted with, payment in full is expected as each visit. You may pay as a cash pay patient, or you may try contacting your insurance company for possible in-network coverage. An addition form will need to be filled out if this is the case. If you are insured with an insurance company that we are contracted with you will need to make sure that you have a valid insurance card present along with a photo I.D. If you have an insurance that we are contracted with and do not have an up-to-date insurance card with you, you must pay in full with cash, check, or credit card until we can verify your insurance coverage. Knowing your own insurance plan and benefits is your responsibility. We do not sell or advertise insurance here at Yeager Foot and Ankle Center; we only provide medical attention. Please contact your insurance company with any questions or concerns that you may have.
2. **Co-payments and deductibles.** All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. We do not pick your co-pay or deductible amount. Failure on our part to collect these payments from patients is considered fraud. Please help us in upholding the law by paying your dues at each visit.
3. **Non-covered services.** Please be aware that some and perhaps all the services rendered here at Yeager Foot and Ankle Center may or may not be covered by your insurance company. Each insurance plan is different. Podiatry is considered a Specialty care. Make sure that you understand what is and is not covered under your selected insurance plan. Some services may or may not be considered "Medically Necessary" to Medicare or other insurance companies. You are responsible for these services if they are not covered.
4. **Proof of insurance.** All patients must complete our patient information forms before seeing the doctor. We must obtain a cop of your drivers license and current valid insurance information to provide proof of insurance. If you fail to provide us with the correct information (one) attempt will be made in order to obtain the correct information before you are responsible for the claim.
5. **Claims and submissions.** We will submit all your claims and assist you in any possible way that we can to help get your claims paid. Your Insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is solely your responsibility whether your insurance pays out or not.

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Your insurance benefits are contracted between you and your insurance company; we are not party to your contracts with your insurance company.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit here with Yeager Foot and Ankle Center so that we may make the appropriate changes to your account. If your insurance company does not pay your claim with in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due , you will receive a letter stating that you have up to 30 days to make a payment or set up a payment plan with the office manager. Please be aware that if your balance remains unpaid, we may send your account to an outsourced collections agency. In which case we can no longer assist you with your account balance.
8. **Missed appointments.** Our policy is to charge for missed appointments not cancelled within 24 hours. These charges will be your responsibility and will be billed directly to you in the mail. Please help us serve you and other to our maximum allowance by keeping your appointments.

Our practice provides the best treatment to our patients. Our prices are representative of the usual and customary charges for our immediate area.

Thank you for reading and understanding the payment policy. Please let us know if you have any questions or concerns.

I,_____ have read and understand that I will comply with Yeager Foot and Ankle Center's payment policy.

Patient signature _____ Date _____