Arches
Foot Institute

DR. DAVID LEE

Patient_____ Date_____/_____/_____

Home Address_____

City_____ State_____ Zip_____

Home Phone (_____)_____ Work Phone (_____)_____ext_____

Email _____ Fax Phone (_____)_____

Social Security #_____ Date of Birth_____/_____/_____

Age_____ Sex: Male_____ Female_____ Marital Status: S____ M____ W____ D_____

How did you hear about our office? Check one:

❑ www.ArchesFootInstitute.com ❑ www.CosmeticfootSurgery.com

❑ Mailer ❑ Google ❑ Yahoo ❑ Bing ❑ Friend/family:_____

❑ Doctor: _____❑ Other: _____

Primary or Referring Physician_____ Phone (_____)_____

Patient Employer_____ Occupation_____

It is your responsibility to give us the correct billing information or you will be billed. Please make sure you give our receptionist your insurance card so we can scan it into our system!

Primary Insurance Company_____

ID or Policy #_____ Group #_____

Are you the Policy Holder?_____ If not, please note who is _____

Policy Holder relationship to patient_____ DOB: _____/_____/_____

We only accept Secondary Insurance coverage if MEDICARE is your primary!!

Secondary Insurance Company_____

ID or Policy #_____ Group #_____

Are you the Policy Holder?_____ If not, please note who is _____

Policy Holder relationship to patient_____ DOB: _____/_____/_____

IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGES IN YOUR INSURANCE. FAILURE IN DOING SO MAY RESULT IN CLAIMS NOT BEING PAID AND YOU BEING BILLED FOR THE ENTIRE BALANCE.

I, the undersigned, certify that I (or my dependant) have insurance coverage with the above plan(s) and hereby assign all insurance benefits, if any, otherwise payable to me, directly to **ARCHES FOOT INSTITUTE** for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I also authorize the doctor to release all information necessary to secure the payment of benefits from my insurance company.

Responsible Party Signature_____ Date_____/_____/_____

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INSURANCE/BILLING/COLLECTIONS POLICIES

We would like to emphasize that as your health care provider, our relationship is with you, our patient, and **NOT** with your insurance company. As a courtesy to you and per our contract with your insurance company, we will bill them directly assuming you have given us all your insurance information. We charge what is usual and customary for our area. The patient is responsible for any remaining unpaid charge as determined by your insurance company.

Please understand, you are responsible for knowing what your insurance benefits are, what services and products they pay and don't' pay. If you are in doubt, please contact your insurance carrier. This office assumes no responsibility for your lack of knowledge regarding your insurance benefits. Please understand that payment of your bill is considered part of your treatment.

We accept Visa, Mastercard, Discover, and American Express as well as debit cards, cash, and personal checks drawn on American funds.

We require all copays to be paid at the time services are rendered as indicated in our contract (and yours) with your insurance carrier.

We do offer payment plans for outstanding balances due, not for copayments. Please call our billing department to work that out. **Any accounts sent to collections will be charged an additional 33% -50% fee of the total balance.**

Children of divorced/separated parents

Unless you give us a signed, notarized court order to keep on file, the parent or guardian who brings the child in for their office visit will be considered ultimately financially responsible. We will entrust you to tell our billing dept. who the bill needs to be sent to for any remaining balance after your insurance pays.

We thank you for understanding our financial policies. This has become necessary in order to continue to accept your insurance plans without having to bill you upfront. Our goal is to make your visit with us as pleasant and professional as we can. If you have any questions, please feel free to ask or call our billing dept. for assistance. Thank you again for choosing us for your foot/ankle care.

I understand these policies and agree to be bound by their terms. I also understand that such terms are subject to change or be amended and I will be notified of any such changes or amendments.

_____ _____

Patient/Guardian or Parent Date

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PATIENT_____ AGE_____ DATE_____/_____/_____

SHOE SIZE_____ WEIGHT_____ HEIGHT_____

MEDICAL HISTORY (Circle ones that apply)

- o DIABETES
- o HYPERTENSION
- o HEART DISEASE
- o LUNG DISEASE
- o LIVER DISEASE
- o INFECTIOUS DISEASE
- o ARTHRITIS
- o HEPATITIS
- o GOUT

OTHER: _____

_____

ALLERGIES TO MEDICATIONS (Circle ones that apply)

- o NONE
- o ASPIRIN
- o PENICILLIN
- o SULFA
- o IODINE
- o CODIENE
- o CORTISONE
- o TAPE
- o GLOVES-LATEX
- o OTHER _____

CURRENT MEDICATIONS

1._____
2._____
3._____
4._____
5._____

PAST SURGERIES (past 10 years)

1._____
2._____
3._____
4._____
5._____

What foot/ankle problem brought you to our office today? _____

_____

How long has this problem been present?_____

Have you had any treatment?_____

If yes, who performed the treatment?_____

Is the problem the result of an injury? Yes _____ No _____

If yes, what is the date of injury? _____/_____/_____

Where did the injury occur?_____

If the injury occurred at work, has your employer been notified?_____

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Bell Road at Grand Avenue (HWY 60) Closure

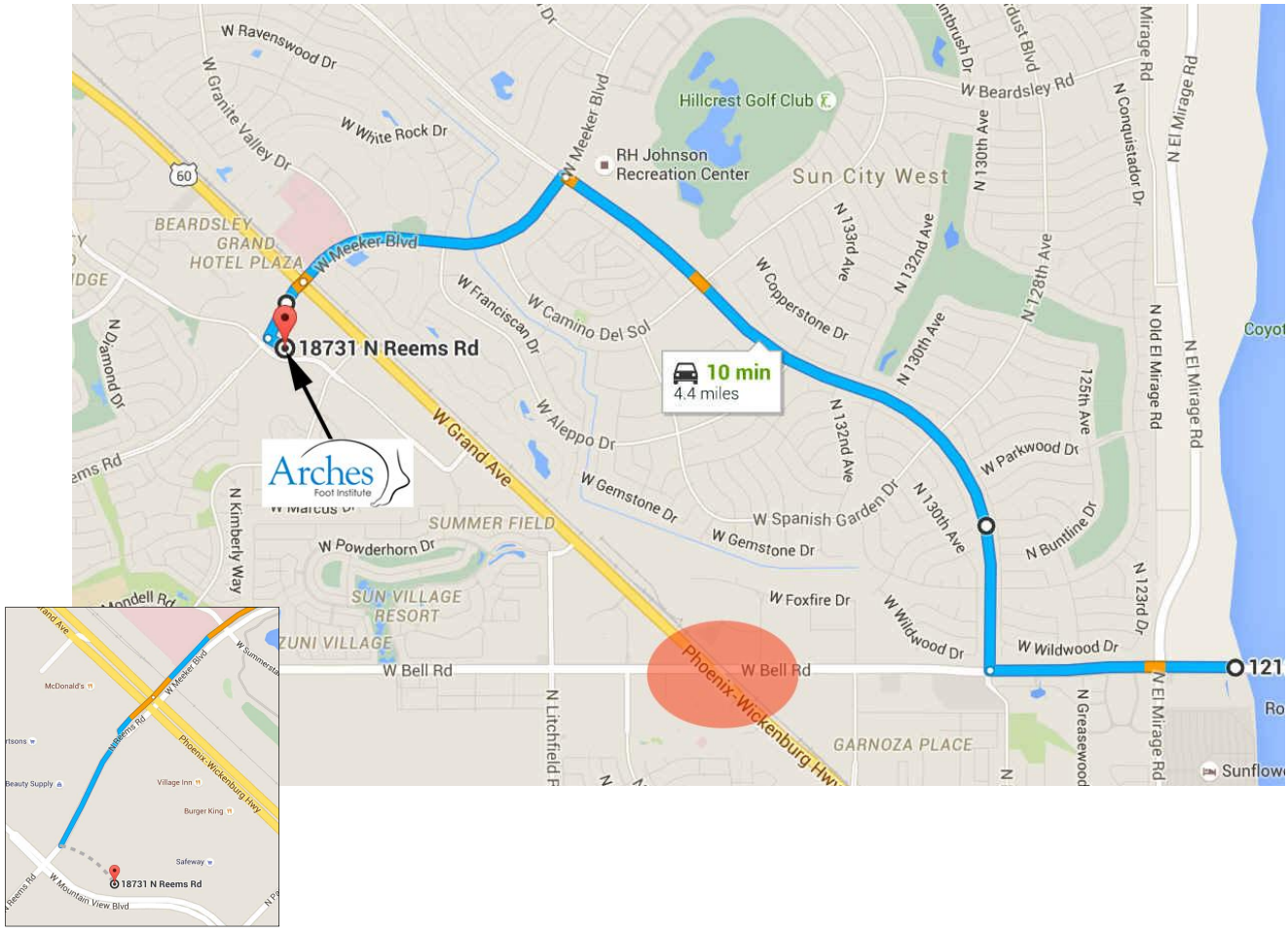
April 1, 2016 to May, 2017

Due to construction of a new interchange bridge, the Bell Road / Grand Avenue intersection will be closed until Spring, 2017.

The recommended detour for those coming West on Bell from Peoria/Glendale is to detour via RH Johnson Blvd.

Directions to Arches Foot Institute from Peoria/Glendale:

- Heading west of Bell Rd, go past El Mirage Road approximately ½ mile.
- Turn RIGHT onto R.H. Johnson Blvd and go for 2.3 miles.
- Turn LEFT onto W. Meeker Blvd. (After ½ mile, you will pass Del Webb Hospital on your right).
- Head straight ACROSS Grand Avenue (W. Meeker becomes N REEMS Road)
- Prepare to turn left into the driveway JUST BEFORE the first intersection (At Mountain View).



18731 N Reems Rd, Suite 640, Surprise, AZ 85374 (623) 328-8577