Rudolph La Fontant, DPM **Foot & Ankle Institute of Iowa**

3613 Beaver Avenue Des Moines, Iowa 50310
Phone: (515) 223-5219 Fax: (515) 223-9344
E-mail: frontdesk@mydoctorrudy.com

Name: _____ Today's Date: _____
First Middle Last

Home Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: ( )_____ Cell Telephone: ( )_____

Birthdate: _____ Age: _____

Are you: (circle one) single married widowed divorced

Email Address: _____
May we send information to your email? Yes No

Occupation: _____ SSN: _____
Employer: _____ Years There: _____
Employer's Address: _____ City: _____
State: _____ Zip: _____ Work Phone: ( )_____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____
Home Address: _____ City: _____
State: _____ Zip: _____
Telephone: ( )_____ Birthdate: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____ Years There: _____
Employer's Address: _____ City: _____
State: _____ Zip: _____ Work Phone: ( )_____

Name of Spouse/Partner/Guardian: _____ Birthdate: _____
Age: _____ Occupation: _____ SSN: _____
Employer: _____ Years There: _____
Employer's Address: _____ City: _____
State: _____ Zip: _____ Work Phone: ( )_____

Patient Name: _____

In case of emergency, contact: _____
Relationship to you: _____
Home Phone: ( )_____ Work Phone: ( )_____

How did you learn about our practice?

- Insurance Co. (which co.) _____
- Internet or Website (e.g., Google, Bing, etc.) _____
- Physician _____
- Friend/Family _____
- Phone Book (which one) _____
- Other _____

May we contact you at work? Yes No

May we leave a message for you at work? Yes No

Can we leave a voice mail message for you with the patient only? Yes No

Can we leave a voice mail message for you with your spouse/partner/guardian?
Yes No

Can we leave a voice mail message for you with anyone answering the phone?
Yes No

Any other information you feel that we should know about? _____

Rudolph La Fontant, DPM **Foot & Ankle Institute of Iowa**

3613 Beaver Avenue, Des Moines, Iowa 50310
Phone: (515) 223-5219 Fax: (515) 223-9344
E-mail: drlafontant@gmail.com

INSURANCE INFORMATION

Patient's Name: _____ Today's Date: _____
First Middle Last

[Primary Insurance]
Name of Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____
Group Number: _____ Policy ID Number: _____

[Secondary Insurance]
Name of Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____
Group Number: _____ Policy ID Number: _____

Did your injury happen on the job? Yes No
If yes, on what date did the injury occur? (if applicable) _____
Did you report the accident to your employer? Yes No

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. ***Please remember that you are responsible for all deductible, copay, and non-covered service amounts.*** See our complete financial policy for details.

Method of Payment for Today's Visit: ___Cash ___Check ___Visa/MC

Insurance Agreement:

I hereby name the Doctor and/or medical practice given below, hereafter referred to as doctor, as my assignee. I instruct my health care benefits plans provider, hereafter referred to as the Plan, to pay the Doctor directly for all professional and medical services provided. Payment should be made by means of electronic funds transfer or by checks made payable and mailed directly to the Doctor.

Rudolph La Fontant, DPM, 2629 Beaver Avenue, Suite 15, Des Moines, IA 50310

Or if my current policy prohibits payment directly to doctors, then I hereby instruct and direct the Plan to make all checks payable to me and mail the payments to me in care of the Doctor as given directly above.

This is a direct assignment of my rights and benefits under this policy.

I grant the Doctor a limited Power of Attorney to sign my name in order to deposit and negotiate any payment received from the Plan and apply the funds received toward my outstanding balance. These payments will not exceed my indebtedness to the above –designated Doctor. I agree to promptly pay any remaining balance due on all professional and medical service charges over and above payments) from the Plan. This assignment shall remain in effect until cancelled in writing by the Doctor.

A photo copy of this agreement, or an electronic facsimile thereof, shall be considered effective as the original.

I understand that personal information about me will be needed by the Doctor and the Plan to determine and communicate what services or benefits are covered by the Plan, and to submit or process a claim for payment on services rendered, I give the Doctor, the Plan, the Centers for Medicare and Medicaid services their agents and any other holder of information about me, authorization to release and/or exchange medical billing, and collection information.

The Responsible Party who signature appears below agrees to the following:

The Doctor, Associate Doctor, and staff of the Medical Practice, named on this form and hereafter referred to as Doctor, are authorized, to medically treat the patient named on this form.

Doctor if authorized to collect, use, and exchange individually identifiable health information consisting of the patient's past, present, and future medical information and other personal information to treat the patient, communicate with the patient's other healthcare providers, seek payment, carry out necessary business functions and mandated government reporting requirements. These situations and others, as well as your rights regarding the information are explained in our separate Notice of Privacy Practices Provided to you.

The Responsible Party agrees to pay for all fees and charges for supplies, services, and treatment that are incurred by the patient per the terms of this agreement and authorize Doctor or agents thereof to make credit investigations, including employment verifications. All charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date. The Responsible Party remains financially responsible for the patient until the Doctor receives their notification in writing to the contrary.

Not all services and/or fees are covered or paid by the Responsible Party's health plan. Thereof, the Responsible Party agrees to pay for all deductibles, co-payments, non-covered services and any portion of covered services not paid in full by the Plan and understands that such payments are due at the time of service or immediately upon presentation of the bill.

All proceeds from the Plan are assigned to the Doctor where applicable. Payments to Doctor may not be withheld, delayed, or excused for any reason, including the outcome of the medical treatment, liens, lawsuits, and coverage determination by the Plan or their processing of claims, the financial insolvency of the Plan, and/or their contracted intermediaries and medical groups.

If any account balance is not paid in full within 60 days, the entire account balance will be subject to a monthly finance charge of 1.5% (APR 18%). These rates and charges are subject to change upon written notice 30 days in advance of changes.

If any account balance should remain unpaid for 60 days and Doctor refers the account to a collection agency or attorney for collection, Responsible Party agrees to pay the costs of collection and that such fees and costs may be added to the account balance. In a legal action between the parties in this agreement to collect an unpaid balance due for medical services rendered, the prevailing party shall be entitled to recover reasonable attorney's fees and costs.

The Responsible Party acknowledges receipt of Doctor's office policy that includes the terms of this Financial Agreement, Insurance Agreement, and authorization for treatment and information release. This form together with the Doctor's office policy contains the entire and only agreements between the parties. There are no other agreements, provisions, representations, or warranties, expressed or implied. The provisions of these agreements shall not be modified except for an instrument in writing assigned by the parties hereto.

I authorize the release of any medical information necessary to process my claim.

Signed: _____
(Patient or responsible party)

_____
Printed Name

Date: _____

I authorize payment of medical and surgical benefits to Foot & Ankle Institute of Iowa.

Signed: _____
(Patient or responsible party)

_____
Printed Name

Date: _____

Rudolph La Fontant, DPM **Foot & Ankle Institute of Iowa**

3613 Beaver Avenue, Des Moines, Iowa 50310
Phone: (515) 223-5219 Fax: (515) 223-9344
E-mail: frontdesk@mydoctorrudy.com

Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

How May I Pay?

We accept payment by cash, check, VISA, and Mastercard.

Do I Need A Referral?

If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. **If you are unable to obtain the referral at that time, you will be rescheduled.**

Which Plans Do You Contract With?

Please see attached list.

What Is My Financial Responsibility for Services?

Your financial responsibility depends on a variety of factors, explained below.

Office Visits and Office Services

If You Have...	You Are Responsible For...	Our Staff Will...
Commercial Insurance Also known as indemnity, "regular" insurance, or "80%/20% coverage."	Payment of the patient responsibility for all office visit, x-ray, injection, and other charges at the time of office visit.	Call your insurance company ahead of time to determine deductibles and coinsurance. File an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	If the services you receive are covered by the plan: All applicable copays and deductibles are requested at the time of the office visit. If the services you receive are not covered by the plan: Payment in full is requested at the time of the visit.	Call your insurance company ahead of time to determine copays, deductibles, and non-covered services for you. File an insurance claim on your behalf.
HMO with which we are not contracted.	Payment in full for office visits, x-ray, injections, and other charges at the time of office visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company.
Point of Service Plan or Out Of Network PPO	Payment of the patient responsibility—deductible, copay, non-covered services—at the time of the visit.	Call your insurance company ahead of time to determine out of network benefits, copays, deductibles, and non-covered services. File an insurance claim on your behalf.
Medicare	If you have Regular Medicare, and have not met your $100 deductible, we ask that it be paid at the time of service. Any services not covered by Medicare are requested at the time of the visit. If you have Regular Medicare as primary, and also have secondary insurance or Medigap: No payment is necessary at the time of the visit. If you have Regular Medicare as primary, but no secondary insurance: Payment of your 20% copay is requested at the time of the visit.	File the claim on your behalf, as well as any claims to your secondary insurance.
Medicare HMO	All applicable copays and deductibles at the time of the office visit.	File the claim on your behalf, as well as any claims to your secondary insurance.
Worker's Compensation	If we have verified the claim with your carrier	

If You Have...	You Are Responsible For...	Our Staff Will...
	No payment is necessary at the time of the visit. If we are not able to verify your claim Payment in full is requested at the time of the visit.	Call your carrier ahead of time to verify the accident date, claim number, primary care physician, employer information, and referral procedures.
Worker's Compensation (Out of State)	Payment in full is requested at the time of the visit.	Provide you a receipt so you can file the claim with your carrier.
Occupational Injury	Payment in full is requested at the time of the visit.	Provide you a receipt so you can file the claim with your carrier.
No Insurance	Payment in full at the time of the visit.	Work with you to settle your account. Please ask to speak with our staff if you need assistance.

Surgery

If your physician recommends surgery, you will be escorted to his Surgery Coordinator. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it.

The Surgery Coordinator will request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. A cost estimate which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan, will be explained by the Surgery Coordinator.

What if My Child Needs to See the Physician?
A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Foot and Ankle Institute of Iowa.

I authorize Foot and Ankle Institute of Iowa to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Date **Signature** **Printed Name**

Rudolph La Fontant, DPM **Foot & Ankle Institute of Iowa**

3613 Beaver Avenue, Des Moines, Iowa 50310
Phone: (515) 223-5219 Fax: (515) 223-9344
E-mail: frontdesk@mydoctorrudy.com

HEALTH HISTORY

Name: _____ Date: _____

Please describe your foot and/or ankle problem: _____
_____
_____

When did your problem begin? _____
Have you had this problem before? _____
If yes, how long ago? _____

Regarding your feet, what symptom(s) best describes your current problem *(check all that applies):*

○ Swelling ○ Pain ○ Numbness ○ Tingling ○ Color Changes
○ Other _____

Describe any prior treatment(s) for this problem (if any): _____
_____
If yes, by whom and when? _____

Do you have any medication allergies? ○ Yes ○ No
If yes, what medications and what reaction(s) did you have? *(e.g., rash, difficulty breathing, etc.)* _____
_____

What medications (prescribed and/or over the counter) are you currently taking?
(Please provide list, if available) _____
_____
_____

Please list any surgeries or hospitalizations: _____
_____
_____

FAMILY HISTORY

Name: _____ Date: _____

Have you or any family member had or currently have any of the following? *(Please check all that apply) If not mark N/A*

Diabetes
○ You ○ Family (Relationship): _____
High Blood Pressure
○ You ○ Family (Relationship): _____
Stroke
○ You ○ Family (Relationship): _____
Heart Attack
○ You ○ Family (Relationship): _____
Congestive Heart Failure
○ You ○ Family (Relationship): _____
High Cholesterol
○ You ○ Family (Relationship): _____
Cancer (type) _____
○ You ○ Family (Relationship): _____
Epilepsy
○ You ○ Family (Relationship): _____
Osteoarthritis/Rheumatoid Arthritis
○ You ○ Family (Relationship): _____
Gout
○ You ○ Family (Relationship): _____
Poor Circulation
○ You ○ Family (Relationship): _____
Hepatitis
○ You ○ Family (Relationship): _____
Leg/foot/sores/ulcers
○ You ○ Family (Relationship): _____
Blood Clots
○ You ○ Family (Relationship): _____
Skin Trouble/Rashes
○ You ○ Family (Relationship): _____

HIPAA Privacy Rule

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that Foot & Ankle Institute of Iowa's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review Foot & Ankle Institute of Iowa's Notice of Privacy Practices prior to signing this acknowledgement

- Foot & Ankle Institute of Iowa reserves the right to change its Notice of Privacy Practices and prior to implementation of this and will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness_____

Printed Name of Individual or Legal Representative _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____

_____

Foot & Ankle Institute of Iowa

3613 Beaver Avenue Des Moines, Iowa 50310
Phone: 515.223.5219 **Fax:** 515.223.9344
Email: fai@mydoctorrudy.com

Appointment Cancelation Policy

A $25.00 Fee will be Billed directly to all patients who are a NO SHOW. You MUST call and cancel your appointment at least 48 hours prior to your appointment time. We have a secure voice mail system; you can leave a message 24 hours a day 7 days a week. This allows other patients to be offered the available time slot. By Signing this Form, you agree to the terms of our Policy in this office. Thank you for your understanding and corporation.

_____
Signature

_____
Date