

WELCOME TO OUR OFFICE

AMERICAN FOOT & ANKLE SPECIALISTS
10900 N. Scottsdale Rd. Suite 206 • Scottsdale, Arizona 85254 • 480-483-9000 • F: 480-483-1791
9421 W. Bell Road, Suite 105 • Sun City, Arizona 85351 • 623-977-8388 • F: 623-977-5242

Michael B. Stegman, D.P.M., F.A.C.F.A.S.

John T. Erotas, D.P.M. F.A.C.F.A.S.

PLEASE PRINT:

Patient Name: _____
Last First MI Nickname you use if any

Address: _____
Street City State Zip Code

Permanent Address: _____
Street City State Zip Code

Home Phone: _____ E-mail Address: _____

Cell Phone: _____ SS# _____ - - Sex: Male / Female

Work Phone: _____ Date of Birth: _____ Age: _____

Married
Single
Divorced
Widowed
Student
Dependent
Other

RESPONSIBLE PARTY:

Name: _____
Last First MI

Address: _____
Street City State Zip Code

Relationship: _____ Phone: _____

Your Employer: _____ Phone: _____ Ext: _____

Address: _____
Street City State Zip Code

Spouse's Name: _____ Birth date: _____

Employer: _____ Spouse's SS#: _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____

FAMILY PHYSICIAN: _____ PHONE: _____

INSURANCE:

Primary Insurance: _____ Policy I.D.#: _____

Name of Insured: _____ Date of Birth.: _____ Group Number: _____

Secondary Insurance: _____ Policy I.D.#: _____

Name of Insured: _____ Date of Birth.: _____ Group Number: _____

ASSIGNMENT: I hereby assign my insurance benefits to be paid direct to the supplier of services rendered;

Patient Signature: _____ Date: _____

RELEASE: I authorize the release to my insurance carriers any information necessary to process this claim.

Patient Signature: _____ Date: _____

PATIENT'S CHART NUMBER _____



A M E R I C A N Foot & Ankle Specialists

Our Financial Policy

We try to provide the highest quality of care to our patients while being considerate of the cost. To help us achieve this and to minimize our administrative costs, we ask that you pay your bill at the time of your visit.

Your Insurance:

We will bill those plans with which we have a signed contract. You will be responsible for all co-pay and deductible amounts at the time of your visit. We will provide you with a form to submit to your insurance company, if you are on a non-contracted plan. You are responsible, however, for paying the entire bill at the time of service. You will then receive reimbursement directly from your insurance company.

- I fully understand that I am financially responsible for all co-pays and deductibles required by my insurance plan, to be paid at the time of each visit.
- I understand that I am financially responsible for any services that my plan determines to be "non-covered". I understand that payment is expected at the each visit unless other arrangements have been made.
- I understand that if the doctors are not participants in my insurance plan I will be responsible for full payment on the day of service and that I will be responsible for filing a claim with my insurance plan.
- I understand that my insurance may not pay my entire bill and that I will receive a bill for the portion of the fees that are my responsibility. Payment is due upon receipt of this bill.
- I understand that interest may be charged on any unpaid balance at 1.8% per month.
- I understand that I will be billed \$35.00 for all checks that are returned by my bank.
- I understand that the office is not able to verify insurance benefits for every patient, and that I have the ultimate responsibility to know my insurance coverage.
- I understand that I am responsible for knowing my plan's benefits and for selecting a physician on the plan.
- I further agree to pay a \$10.00 late fee for any accounts over 60 days late and all finance charges such as collection costs, attorney fees, and any other costs that may be incurred to enforce collection of any amount outstanding.
- I understand that my chart and any X-Rays. Belong to the doctor and there will be a charge for copies. Minimum copying charge is Chart: \$30.00; X-rays: \$7.00 per sheet; Digital X-ray disk: \$3.00
- I further understand that I must give 48 hours notice of appointment cancellation or I will be billed \$55
- I authorize release of medical information to my insurance company. If I do not authorize release, then I understand that payment will likely be denied or delayed by my insurance company. In this circumstance, I understand that I will be responsible for my bill. Additionally your insurance card MUST be presented at the time of each visit.

Minor Patients

For all services rendered to minor patients (under the age of 18), we will look to the adult accompanying the patient and/or the parent or guardian with custody for payment.

Referrals

If your insurance plan requires that we obtain a referral for you to seek medical attention with another doctor, you must notify our office seven (7) days in advance of your appointment. Otherwise, we cannot guarantee that you will have this referral. In that event, your visit may be paid "out-of-network", if available, according to the terms of your insurance policy.

Patient Name

Signature of Patient or Responsible Party

Date

**AMERICAN FOOT & ANKLE SPECIALISTS
10900 N. SCOTTSDALE RD, #206
SCOTTSDALE, AZ 85254
480-483-9000**

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
FOR AMERICAN FOOT & ANKLE SPECIALISTS**

I acknowledge that I was provided or offered a copy of the Notice of Privacy Practices. I have read (or had the opportunity to read if I so chose) this notice and I understand its contents.

PATIENT NAME (PLEASE PRINT)

DATE

PARENT OR AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

~~SIGNATURE~~



A M E R I C A N Foot & Ankle Specialists

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding
the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.



A M E R I C A N Foot & Ankle Specialists

Modern, Progressive Care from the Hands of Experience

November 1, 2008

Letter to our Patients

As of January 1, 2009 there will be a policy change by our office regarding secondary insurances. This change will mainly affect Medicare patients with a secondary insurance that does not cross over from Medicare. In most cases Medicare will automatically forward claims to your secondary carrier.

Due to many cost increases we will no longer send claims on to secondary insurances that are not automatically forwarded by Medicare. At the time of your visit you will be given all necessary information needed for you to forward to your secondary carrier after you have received your EOB reimbursement information from Medicare. At the time of your visit you will be responsible for all co-pays, deductibles and secondary insurance costs.

No exceptions will be made with this policy. In most cases our office can tell you if your claims are automatically forwarded. In some cases a call by you to your Medicare representative requesting automatic forwarding of information will activate this process.

We are sorry for any inconvenience this change in policy causes but it has become cost prohibitive for us to continue processing these claims to your secondary insurances. Know that we will make every effort to help you in this transition.

Also, in January we will be updating our patient records for any changes in addresses, phone numbers and insurance coverage information. Please be prepared with any new information or insurance cards.

Thank you for your assistance. Know that these changes will help us continue to deliver high quality, cost effective care to all of our valued patients.

Sincerely,

American Foot & Ankle Specialists
Drs. Erotas and Stegman and staff

Michael B. Stegman, D.P.M.
Diplomat, American
Board of Podiatric Surgery
Board Certified in
Foot and Ankle Surgery
Fellow, American College
of Foot & Ankle Surgeons
Clinical Instructor,
Arkville College of Osteopathic
Medicine, Allied Health Program

John T. Erotas, D.P.M.
Diplomat, American
Board of Podiatric Surgery
Board Certified in
Foot and Ankle Surgery
Fellow, American College
of Foot & Ankle Surgeons
Associate, American Academy
of Podiatric Sports Medicine
Clinical Associate Professor,
California College of
Podiatric Medicine
Clinical Instructor,
Arkville College of Osteopathic
Medicine, Allied Health Program

Members:
American Podiatric
Medical Association
Arizona Podiatric
Medical Association

ring, effective treatments for:
Grown Toenails
Bunions and Corns
Arthritic Foot Problems
Diabetic Foot Problems
Fungal and Skin Problems
Foot and Ankle Pain
Athletic Injuries
Bunions
Heel Pain
Plantar
Fasciitis
Sprains
Blisters
Plantar Warts

refully planned treatments:
Endoscopic Ankle Surgery
Podiatric Surgery
Physical Therapy
Office X-rays
Computer Assisted Orthotics
Conservative Footcare
Second Opinions

Medicare assignment accepted
Medicaid plans available
Other insurance plans accepted
Visa and MasterCard accepted