The Foot Clinic, LLC
Ali Davis, D.P.M. F.A.C.F.A.S.
Board Certified in Foot and Ankle Surgery and Wound Care

4601 W 109th St, Ste 314
Overland Park, KS 66211
P: (913) 364-1314; F (913) 364-1160
www.dralidavis.com

New Patient Intake Forms

How did you hear about Dr. Davis/The Foot Clinic? Internet/Google Friend/Family Referring Doctor: Insurance Company Facebook Other:

First Name: **Middle Initial:** **Last Name:** **Date of Birth:**

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Student

GENDER IDENTITY: ☐ Male ☐ Female ☐ Transgender Female ☐ Transgender Male ☐ Non-Binary

Appointment Reminder Consent
Please Circle up to TWO:
Text Phone call to Home
Email Phone call to Mobile

Please Note: You will receive 3 automated reminders.

Mobile Phone Number:

Home Phone Number:

Email Address:

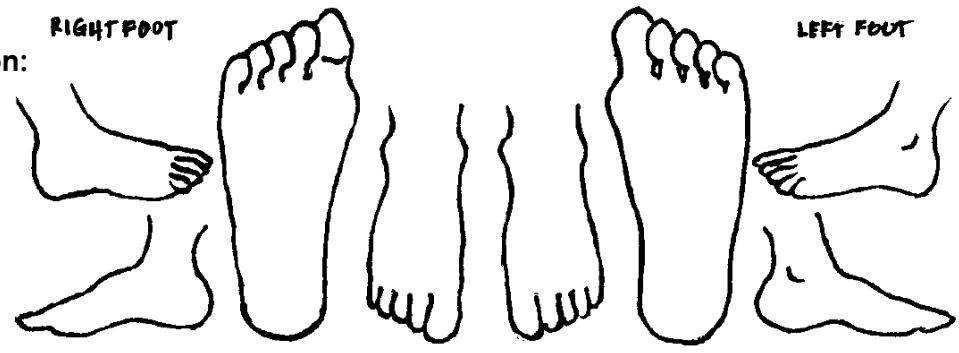
Local Pharmacy Name & cross streets OR phone number:

Current Medications:

Emergency Contact Name: **Relationship:** **Phone#:**
(We may contact this person if we cannot get ahold of you.)

Please mark the symptom & location:

Ingrown Toenail
Pain
Swelling
Wound



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HIPAA ACNKNOWLEDGEMENT AND CONSENT

_____ **(Patient Initials)** I give permission for reasonable and necessary medical examinations, testing and treatment to be performed at The Foot Clinic, by the physician. By signing below, I am indicating that:

(1) I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended.
(2) I consent to treatment at The Foot Clinic or any other satellite location under the care of Dr. Davis.

_____ **(Patient Initials)** I have the right to discuss the treatment plan with the physician about the purpose, potential risks and benefits of any test ordered for myself/my child. If I have any concerns regarding any test or treatment recommend by the health care provider, I am encouraged to ask questions. I give consent for The Foot Clinic to leave test results, orders, referral information and appointment reminders on my voicemail if unable to reach me personally.

Disclosure to family and/or friends:
I give permission for my Protected Health Information (PHI) to be disclosed for purposes of communicating results, findings and care decisions to the family member and others listed below.:

_____

Name: Relationship: Phone #:

_____

Name: Relationship: Phone #:

_____
Print Name:

_____ _____
Signature: **Date:**

The consent will remain fully effective until it is revoked in writing.
You have the right at any time to discontinue services.

Would you like an invitation to our patient portal, Patient Fusion? No Yes
If Yes, please include your email address on page 1.

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FINANCIAL POLICY

Financial Responsibility

I. The Foot Clinic will collect your deductible, co-pay, uncovered services, or coinsurance you are responsible for at the time of your visit. It is the patient's responsibility to know the terms of their insurance plan. *Please be prepared to pay copays and balances at the time of service.*

If you have not met your deductible, we will collect payment for the estimated amount allowed by your insurance plan or New Patient visits are $100; Follow up visits are $50.

II. If your insurance denies payment on your account, you will be asked to pay by check, cash, or charge.

III. ***You may receive statements or notifications via text message and/or e-mail.***

IV. **TERTIARY:** The Foot Clinic will submit claims to primary and secondary insurances *only*. It is your responsibility to provide your third insurance with a billing statement of any remaining unpaid charges. Please be aware that any amount remaining AFTER insurance processes a claim is your financial responsibility.

V. NO SHOW POLICY: Appointments missed without notice or cancelled less than 24 hours' notice will be subject to the $25.00 No Show Fee. **Two No-Shows is an automatic dismissal from the practice.**

VI. **COLLECTIONS:** Should your account become delinquent and over 90 days old, you will need to contact our billing department to establish a payment arrangement before making another appointment.

VII. **RETURNED CHECKS:** There is a $40 charge for returned checks or declined credit card charges from mailed in payments.

VIII. **SELF-PAY PATIENTS:** This category includes patients with no insurance and the patients who have an **insurance plan with which we do not participate** or **an insurance plan that does not provide podiatry benefits**. Payment for medical services is required prior to services being rendered. We accept Visa, MasterCard, Discover and American Express, checks, cash, and money orders.

By signing below, I agree that I am financially responsible for any charges incurred for missed appointments in which I did not give the required advanced notice.

_____
Print Name:

_____ _____
Signature: **Date:**