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

First: **Middle Initial:** **Last:** **DOB:**

Address: **City:** **State:** **Zip:**

Mobile#: **Home#:**

Email Address:

CHECK ONE: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Student

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

Consent for Appointment Reminder Preference (Please Circle Up to Two):		
Text 1 day prior	**Phone Call 1 day prior**: Home or Mobile?	**Email 1 week prior**

Please Note: *All reminders are automated. Please be sure to follow the instructions when your reminder is delivered to "**CONFIRM**" your appointment when applicable.*

Primary Insurance *Name*:

Secondary Insurance *Name*:

Primary Care Doctor: **Year of last visit:**

Local Pharmacy: **Pharmacy Address/Cross Street:**

Current Medications:

Emergency Contact Name: **Relationship:** **Phone#:**

Brief explanation of toe/foot/ankle issue:

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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.

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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 of Financially Responsible Party:

_____ _____

Signature of Responsible Party: **Date:**

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

PATIENT DEMOGRAPHIC INFORMATION

To be compliant with the Government Regulations we need the following information:

Race:

( ) American Indian
( ) Alaska Native
( ) Asian
( ) Black or African American
( ) Decline to Specify
( ) Native Hawaiian or Pacific Islander
( ) White or Caucasian
( ) Other
( ) Hispanic

Ethnicity:

( ) Hispanic or Latino
( ) Not Hispanic or Latino
( ) Decline to Specify

Primary Language:

( ) English
( ) Other _____

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