Dakota
FOOT & ANKLE CLINIC

1733 E. Capitol Ave
Bismarck, ND 58501
Office 701-255-3338, Fax 701-255-3338
Dr. Brian Gale

FINANCIAL POLICY

Thank-you for choosing Dakota Foot and Ankle Clinic as your healthcare provider. Our goal is to provide quality care in a comfortable atmosphere, in the timeliest manner possible. Please read carefully and **sign at the bottom** of this page indicating your understanding of these policies. For your convenience, we accept cash, check, Visa, MasterCard, and Discover.

Office Responsibility

1. An exact fee cannot be determined until the patient has been evaluated and the doctors have reviewed the finding for each date of service. Please understand that there are separate charges for each procedure which may include: office visits, x-rays, injections, casts, braces, and/or any other procedure done within the office or hospital setting (surgeries).

2. Dakota Foot and Ankle Clinic will bill the patient's insurance company and supply all information needed to accurately process the patient's claim. In addition, Dakota Foot and Ankle Clinic will obtain the patient's copay and deductible information prior to the visit. Copay is due at the time of service as well as 60% of any fees incurred, if the patient's deductible has not been met. If the patient is experiencing financial difficulties, Dakota Foot and Ankle will arrange a payment plan to fit the patient's budget. However, failure to pay a patient balance may result in an inability to schedule future appointments until the balance has been paid in full. Delinquent accounts may be referred to a collection agency.

Patient Responsibility

1. We believe your time is as valuable as ours. Please arrive on time for your scheduled appointment. If you are more than 15 minutes late, it may be necessary to reschedule your appointment. A 24-hour notice is required for cancellation of appointments. We strive to minimize any wait time. However, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

2. It is the responsibility of the insured to understand his/her insurance coverage. Patients are responsible for services not covered by their insurance at the time services are rendered, which may include: office visits, co-pays and/or deductibles.

_____	_____	_____
Signature of Patient/Guardian	Print Name of Patient	Date

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AUTHORIZATION/ASSIGNMENT/RELEASE FORMS

PATIENT'S NAME:_____ ***DOB***:_____

Please ***INITIAL***

1. _____ I hereby give my permission to Dakota Foot and Ankle Clinic, P.C.to perform necessary evaluations, administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition.

2._____ I acknowledge that I can view a copy of the Notice of Privacy Practices at http://www.dakotafootankle.com/docs/Notice%20of%20Privacy%20Practices.pdf or if I choose; get a copy at Dakota Foot and Ankle clinic's office. And that I have read (or had the opportunity to read if I so choose) and understood the Notice.

3._____ I authorize, to the extent necessary, disclosure of medical information to assist in processing my insurance claim and to communicate with other treating physicians. Furthermore, I assign all payment of medical benefits provided by Health Care Finance Administration (Medicare), my commercial insurance company, or my secondary/supplemental insurance policy for medical/surgical care to Dakota Foot and Ankle Clinic, P.C.

Name of Primary Physician**:** _____

***DEMOGRAPHIC*: (please fill out each section of demographic)**

Email Address:(Patient or POA) _____

(Please provide in order to receive access to your medical records online or write NA)

Preferred Method of Contact: ☐ Cell Phone ☐ Home Phone ☐ Work Phone

Number: _____

***Ethnicity*:** ☐ Hispanic ☐ African American ☐ Asian ☐ Caucasian (White)
☐ Native American ☐ Other_____

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

The items initialed above by me or my authorized representative were explained and are true to the best of my knowledge.

Print Patient or POA Name_____

Patient or Auth. Rep. Signature:_____Date:_____

Witnessed By:_____
(for signature from DFA staff)

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DEMOGRAPHICS

Name: _____

Date of Birth: _____ Age: _____

Gender (Please Circle): Male Female

If Female, are you pregnant? Yes No

Who is your Primary Care Doctor? _____ Last time seen by Primary Care Doctor? _____

Height: _____ Weight: _____

ONGOING MEDICAL HISTORY

What is your chief foot/ankle/leg complaint today? _____

How long has it been bothering you? _____If applicable, what was the date of injury?_____

Previous treatments? _____

How would you describe your pain? (Please circle all that apply)

Sharp Aching Burning Throbbing Shooting Pins and Needles Other_____

MEDICAL HISTORY (Check all that apply) N/A___

___ AIDS/HIV	___ Emphysema	___ Liver Disease	___ Stroke/Seizure
___ Anemia	___ Gout	___ Osteoarthritis	___ Tuberculosis
___ Asthma	___ Hepatitis	___ Phlebitis	___ Thyroid condition
___ Cancer	___ High Blood Pressure	___ Pneumonia	___ Ulcers
___ Diabetes	___ High Cholesterol	___ Pacemaker	___ Varicose Veins
___ Eczema	___ Kidney Disease	___ Rheumatoid arthritis	___ Joint Replacement
____Heart valve replacement	Other_____		

CURRENT MEDICATIONS: N/A____

_____ _____ _____

_____ _____ _____

PHARMACY NAME and NUMBER:
_____ **N/A___**

HAVE YOU EXPERIENCED…

	Yes	No		Yes	No
Back problems	___	___	Headaches	___	___
Burning, tingling, numbness in toes	___	___	Itchy skin on feet	___	___
Reaction to local anesthetic	___	___	Shortness of breath	___	___
Episodes of fainting	___	___	Swelling of feet/ankles	___	___
Foot/Leg cramps while sleeping	___	___	Dryness of skin	___	___
Foot/Leg cramps while walking	___	___	Hives/Rashes on feet	___	___
Extreme fatigue	___	___	Ear pain/discomfort	___	___
Nausea/Vomiting/Diarrhea	___	___	Vision problems	___	___

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Allergies : Do you have any current allergies Yes NO

If YES, Please check allergies below:

___ Adhesive Tape	___ Local Anesthetics	___ Penicillin
___ Aspirin	___ Shellfish	___ Codeine
___ Demerol	___ Iodine	___ Other _____
___ Latex	___ Sulfa Drugs	

Location of Allergy *(what part of the body does it affect)* :_____

Reaction to Allergy (*please circle*): Rash Chest Pain Swelling Hives Coughing Cramping Vomiting

Difficulty Breathing Runny Nose Other: _____

Severity of Allergy (*please circle*): Very Mild Mild Moderate Severe

MAJOR EVENTS, HOSPITALIZATIONS, SURGERIES N/A____

SURGICAL HISTORY or any other INJURIES/TRAUMAS (Procedure and year)

_____

_____

SOCIAL HISTORY

Previous/current: Tobacco use **YES NO** Alcohol use **YES NO Occasional** Illegal Drug **YES NO**

If yes to tobacco use, for how long? _____ When did you quit? _____

If yes to tobacco use, how many packs per day? _____

Type of Work:_____ Hours of Standing _____ Type of Flooring at work / home:_____/ _____

Time spent exercising per week_____

FAMILY MEDICAL HISTORY N/A_____

(Please place "X" in area if family member has or previously has had medical condition)

	High Blood Pressure	Diabetes	Cancer	Stroke
Mother				
Father				
Brother				
Sister				

Signature of Patient: _____ Date: _____

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