ROCHESTER FOOT AND ANKLE

Name: _____ **DOB:** _____

Sex: ___M ___F **SS #:** _____ **E-mail:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home #: _____ **Cell #:** _____ **Other:** _____

Preferred phone: ___Home ___Cell ___Other

Emergency Contact: _____

Phone #: _____ **Relationship:** _____

_____

What is the reason for your visit today (be specific): _____

_____

_____

_____

How long has this bothered you (be specific): _____

Was this due to an accident or injury: ___Yes ___No; if yes, date: _____

Please describe accident or injury: _____

_____

What treatments have you tried: _____

_____

What testing has been done: _____

Pain Level (on a scale of 1-10 with 10 being the worst): _____

_____

Where do you work: _____

What is your occupation: _____

Name: _____ **DOB:** _____

_____

How did you find out about our practice? ___Physician ___Internet ___Family Member

___Friend ___Other: _____

Who is your Primary Care Provider: _____

Which provider referred you: _____

What pharmacy do you use: _____

Smoking Status: ___Current every day ___Occasionally ___Former ___Never

Do you exercise regularly: ___Yes ___No

What are your activities: _____

CONSENT FOR TREATMENT

I, (or my authorized representative on my behalf) authorize the practice and staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

_____

Patient's Signature **Date**

_____

Parent/Guardian Signature **Date**

3.21.25

Name: _____ **DOB:** _____

FINANCIAL AGREEMENT/COMMUNICATION

Financial Agreement: I acknowledge, that as a courtesy, the practice staff may bill my insurance company for services provided to me. I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance. I understand that there is a fee for returned checks.

Third Party Collection: I acknowledge the practice staff may use the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits: I hereby assign practice staff any insurance or other third party benefits available for health care services provided to me. I understand the practice has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to the practice, I agree to forward all health insurance or third party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefits: I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the practice by the Medicare of Medicaid program.

Consent to Telephone Calls for Financial Communications: I agree that, in order for the practice or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that the practice or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided the practice or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or any related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

_____

Patient's Signature Date

_____

Parent/Guardian Signature Date

3.21.25