LARGO FOOT & ANKLE HEALTH CENTER
AND AMBULATORY SURGICAL CENTER, INC.

Welcome to our office!

Our goal is to provide high quality, comprehensive podiatry service to the community in a cost-effective way. We value quality care, accountability, service, integrity, and experience. We also value our relationships with our patients and their families and friends. Our staff is friendly, knowledgeable, and always eager to help.

About Our Center:

Our office is located at 1450 Mercantile Lane, Suite 151, in Largo (near the Kaiser building). Our regular office hours are 8:30 a.m. to 5:00 p.m. Tuesdays & Wednesdays, Thursdays; 9:00 a.m. to 5:30 p.m., Fridays 8:30 to 2:00; and 10:00 a.m. to 2:30 p.m. on Saturday (open one Saturday a month). A doctor can be reached 24 hours a day, seven days a week at (301) 386-5453.

We accept most insurance plans, though the patient is responsible for all fees. We are happy to assist in filing your insurance claims.

What Is Podiatry?

Podiatry is a healthcare profession specializing in the care of the human foot by medical and surgical means.

Our strengths are the knowledge and flexibility that come from many years of training and experience. Our expertise includes:

- ✓ Arthritis and Bursitis
- ✓ Corns and Calluses
- ✓ Diabetic Foot Care
- ✓ Diagnostic Radiology
- ✓ Foot and Ankle Surgery
- ✓ Fractures
- ✓ Fungal Nail Care
- ✓ Geriatric Foot Care
- ✓ Hammertoes
- ✓ Ingrown Toenails
- ✓ Orthotics
- ✓ Skin Disorders of the Foot
- ✓ Sports Podiatry
- ✓ Sprains
- ✓ Surgery for All Foot Conditions
- ✓ Tendonitis
- ✓ Tumors of the Foot and Ankle
- ✓ Ulcers (Neurotrophic and Diabetic)
- ✓ Wart Removal

"With Dr. Ade Adetunji, your feet are always in good hands."

FINANCIAL POLICIES

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you or your health insurance carrier, payment for office services are due at the time of service. We accept VISA, MasterCard, Bank Cards and cash.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the doctor within a reasonable period of time, we will have to look to you for payment.
- We have made prior arrangements with insurers and other health plans to accept our assignment of benefits. We will use those plans with which we have agreements and will only require you to pay the co-payment insurance or deductible at the time of service.
- If you have insurance coverage under a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service is not covered, or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges for any services rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform this office of all insurance changes and authorization/ referral requirements. In the event this office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to surgery.
- Past due accounts are subject to collection proceedings. All fees, including but not limited to collection fees, attorney fees, and court fees, shall become your responsibility in addition to the balance due this office.

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered.

Signature of Patient/Responsible Party: ____

Printed Name: ___________________________________ Date: __________

Witness: ____ Date: __________

Printed Name of Witness: ___________________________________

_________ Patient Initials (to indicate copy received)

MEDICAL INFORMATION RELEASE/ASSIGNMENT OF BENEFITS/MEDICAL EXAMINATION CONSENT

I hereby authorize the practice to release any medical information regarding my care, should it be necessary for the processing of my claim(s). Payment of medical benefits from the insurance company should be made directly to the medical provider where applicable. A photocopy of this authorization may be honored. I also hereby give my consent to a medical examination when appropriate.

Signature: _________________________________ Date: _____

PATIENT INFORMATION FORM

[] Mr. [] Mrs. [] Miss ____

Last Name First Name

MI

____

Address

____

City State Zip Code

Age: _______ Date of Birth: __________________ SS#: ____________

Marital Status: Single []Married [] Widowed [] Divorced [] Separated []

Home Phone: ___________________ Work Phone: ___________________

Cell Phone: ___________________

E-Mail Address: _______________________________________

Employer's Name and Address: ____

____

Emergency Contact: _________________________________ _________________

Name Phone Number

Primary Care Physician: ________________________________ _________________

Name Phone Number

Responsible Party (if other than patient) NAME______________________________

Address: ____

Subscriber's Name/SS#/Date of Birth: ____

ID#: __________________________________ Group #: ___________________

Secondary Insurance Company: ____

Address: ____

Subscriber's Name/SS#/Date of Birth: ____

ID#: __________________________________ Group #: ___________________

PATIENT MEDICAL HISTORY

What problem brings you to our office today? ___________________________________

____

When and why was the last time you saw a podiatrist? ____________________________

____

If yes, podiatrist's name, address, and phone number: ____________________________

____

If female, are you pregnant? __________ If yes, how many months? ____

Are you currently taking prescription drugs? If yes, please list drug, dosage, and how often you take them: ____

____

____

Have you had a recent chest x-ray? If yes, when? _____________

Have you had a recent EKG? If yes, when? _____________

Have you had a recent blood test? If yes, when? _____________

Have you had any previous surgeries? If yes, when? Please describe: ______________

____

____

Do you have any allergies to medicine? If yes, please describe: ___________________

____

What was the date of your last medical check-up? _______________________________

Do you or have you suffered from any of the following:

Alcohol/Drug Problems []
Allergies/Hay fever []
Alzheimer's Disease []
Anemia []
Arthritis []
Asthma []
Bleeding Problems []
Cancer []
Chest Pain []
Convulsions/Epilepsy []
Diabetes []
Eczema []
Emphysema []
Gall Bladder Disease []
Gout []
Hearing Problems []
Heart Trouble []
Hepatitis []
High Blood Pressure []
HIV Positive []
Joint Pain or Stiffness []
Kidney or Bladder Problems []
Liver Disease []
Lower Back Pain []
Menstrual Problems []
Mental Illness []
Migraines []
Pneumonia []
Polio []
Poor Circulation []
Rheumatic Fever []
Shortness of Breath []
Skin Problems []
Stomach/Intestinal Disease []
Stroke []
Thyroid Problems []
Tuberculosis []
Ulcers []
Venereal Disease []
Vision Problems []
Weight Problems []

Do you smoke? If yes, how much? ____
Do you drink? If yes, how much? ____

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RE: **Hydrotherapy/Whirlpool**

We feel that the hydrotherapy/whirlpool is a vital preparatory and sanitary procedure to prepare the patient for examination and/or treatment by the physician. However, insurance companies do not always deem this treatment a medical necessity and consequently will not cover the cost of this service. In this situation, we will reduce the fee for the hydrotherapy/whirlpool from $35.00 to $15.00 (which is approximately what the insurance company will pay for this service) and the $15.00 will be the patient's responsibility if he or she would like to receive this service. Our office staff will let you know which of these applies to you.

Thank you.

Signature:__________________

Due to HIPAA (Privacy Act), we are requesting that the patient please complete this information sheet.
Please check the appropriate box:

1. I [ ] do [ ] do not authorize a message to be left either on an answering machine or with whomever may answer the phone.
2. I [ ] do [ ] do not authorize release of medical information to outside sources such as insurance carriers, home health agencies, and workman's compensation plans.
   Please list the names of your insurance company, home health agency, and workman's compensation plan.
   ____
3. I [] do [ ] do not authorize the release of medical information to any laboratory or facility for which diagnostic tests are requested by a physician.
   Please list the lab that you wish to use.
   ____
4. I [ ] do [ ] do not authorize release of prescription information to my pharmacy.
   Please list the pharmacy that you wish to use.
   ____
5. I [ ] do [ ] do not authorize release of medical information to my designated caregiver. This includes the person who may be used to pick up written prescriptions or orders for testing.
   Please specify the name of the person or persons as well as the relationship to you.
   ____
   ____
6. I [ ] do [ ] do not authorize release of information to Largo Foot & Ankle Health and Ambulatory Surgical Center if requested by Dr. Adetunji.

I, ____________________________________, being the patient, have completed the above and checked the appropriate boxes and completed the appropriate information. I fully understand that this guideline will be strictly enforced. I am fully aware that if any information needs to be changed that I will need to complete a new form. Furthermore, I realize that if I do not designate a specific pharmacy then I will not be able to receive prescription call-ins. Finally, I acknowledge that if I do not wish for information to be released to insurance companies or the workman's compensations plan that I will be personally responsible or the amount due.

____
Signature of Patient (cannot be completed by a caregiver or staff member)

____
Date

ADVANCE BENEFICIARY NOTICE (ABN)

Note: You need to make a choice about receiving health care items or services.

We expect that Medicare will not pay for the item(s) or services(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, Medicare probably will not pay for:

Items or Services:

- Debridement of Nails As Routine Foot Care
- Debridement of Callous As Routine Foot Care
- Inserts for Foot and Heel Pain

Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully and

- Ask us to explain if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (Estimated Cost$ 80.00) in case you have to pay for them yourself or through other insurance.

Please choose one option, check one box, and sign and date your choice.

OPTION 1. **YES.** I want to receive these items or services.

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. /that is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

OPTION 2. **NO.** I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

____

Signature of Patient or Person Acting on Patient's Behalf

Date ________________

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Medicare will keep your health information, which Medicare sees, confidential.