

Name _____ Date of Birth _____

Established Patient Update Form

Please fill out this form to the best of your knowledge. Your answers help us plan and provide your care.

Personal Information No Changes

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: M F Race: _____ Email: _____

Home Number: _____ Mobile Number: _____

Marital Status: Single Married Widowed Divorced Separated Domestic Partner

PCP: _____ Phone: _____ Last Seen Date: _____

Pharmacy Information No Changes

Pharmacy Name: _____ Phone: _____

Address: _____ City, State, Zip: _____

Insurance Information: Has your insurance changed since your last visit? Yes No

If yes, please provide the updated insurance info:

Primary Ins Info: _____ ID: _____

Secondary Ins Info: _____ ID: _____

If Workers Comp Insurance, please provide us with your Adjustors Information, Claims #, and Date of Accident: _____

Advanced Directives and Resuscitation Preferences

Do you have an Advanced Directive? Yes No

Please select all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Do Not Intubate (DNI) | <input type="checkbox"/> Organ Donor (Registered to donate organs) |
| <input type="checkbox"/> Do Not Resuscitate (DNR) | <input type="checkbox"/> Only Resuscitate (Only resuscitation efforts, no intubation) |
| <input type="checkbox"/> Full Code (All resuscitation efforts will be made) | <input type="checkbox"/> Power of Attorney (Someone designated to make healthcare decisions for you) |
| <input type="checkbox"/> Living Will (A document stating your healthcare preferences) | <input type="checkbox"/> Surrogate Decision Maker Assigned (A person chosen to make decisions if you are unable to do so) |
| <input type="checkbox"/> No Advanced Directive (No current advanced directive in place) | |

Medical Updates

Have there been any changes to your medical history, current medications, or allergies since your last visit? Yes No

If yes, please list: _____

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Friends and family involved in care (Optional)

I permit the following individuals to receive information about my treatment and payment to assist in my healthcare. I understand this permission is valid until revoked.

Name: _____ Phone: _____

Relationship: Spouse/Partner Parent Child Other Relative Friend Other

Emergency Contact (Optional)

Name: _____ Phone: _____

Relationship: Spouse/Partner Parent Child Other Relative Friend Other

Digital Communication Consent

Do you consent to receive **appointment reminders** and **billing information electronically**? **Yes** **No**

Financial Policy

Copayments, Deductibles, and Coinsurance:

- Insurance co-payments are due at the time of your visit.
- Nail biopsies and pathology services are charged along with the office visit.
- Additional charges may apply for external laboratory testing.
- If unable to pay your co-payment, your appointment will be rescheduled.
- A \$75 fee is required if you have a deductible or co-insurance amount due.
- We will file your insurance claims to help maximize your coverage.

Appointment Cancellations and No-Shows:

- Cancellations with less than 24 hours notice will incur a \$50 fee.
- No-show appointments will incur a \$50 fee to reschedule.

Chargebacks and Returned Checks:

- A \$25 fee applies for returned checks or credit card chargebacks.

Past Due Balances:

- Past account balances must be settled before your next appointment.

Authorization and Acknowledgement

I hereby authorize Cutting Edge Foot & Ankle, PLLC, to Provide medical treatment and healthcare services as necessary. Furnish information to insurance carriers concerning my illness, treatments, and care. Assign all payments for medical services rendered to myself or my dependents directly to Cutting Edge Foot & Ankle, PLLC. I understand that it is my responsibility to know my insurance company's policies and accept responsibility for any payments resulting from unmet insurance requirements. By signing below, I acknowledge that I have read, understood, and agree to the above and have received the following policies: **HIPAA Privacy Policy** (Patient Confidentiality and Consent Form) & **Patient Complaints and Grievances Policy**.

Signature: _____ Date: _____