Tipton & Unroe Foot and Ankle Care PSC
6801 Dixie Hwy Ste 134
Louisville, KY 40258
Phone: 502-447-4500 Fax: 502-449-0108

Last First Middle

Pt's Address Street City State Zip

Date of Birth ____/____/____ Age _____ Email address: _____

Home Phone (____) _____ Cell Phone (____)_____

Work Phone (____)_____ Social Security: _____

Family Physician Name:(Not facility name) _____

Preferred Method of Contact: ☐ Home Phone ☐ Mobile Phone ☐ Email ☐ Text

Sex: ☐ Male ☐ Female Marital Status: *Married *Single *Divorced *Widowed

Language: ☐ English ☐ Spanish ☐ Other

Race: ☐ White ☐Black or African American ☐ American Indian or Alaska Native Asian ☐ Native Hawaiian or Other Pacific Islander

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Employer Name: _____ Employer Phone#: _____

Emergency Contact: Name (Different # than above)_____
Phone#:_____
Relation: _____
Can we speak to this person regarding Medical or Billing Info? ☐ Yes ☐ No

Minor Guarantor or Insurance Holder :
Name: _____
Relation to patient:_____
Address: _____
Primary Phone #: (_____) _____-_____
Date of Birth ____/____/____
Sex: ☐Male ☐Female
SS # _____
Marital Status: ☐ M ☐ S ☐ D ☐ W

How did you hear about the office?
☐ Referring Doctor's Name _____ OR ☐Soccer Team

☐ Radio ☐ TV ☐ Yellow Pages ☐ Web ☐ Former Patient ☐ Family & Friends ☐ Insurance ☐Saw Sign

I hereby authorize the release of any medical information necessary to process my insurance. I authorize payment directly to the provider of services. I understand that I am financially responsible for any remaining or unpaid balances.
Please Circle: (Patient, Parent, and Legal Guardian)

SIGNATURE: _____ Date: _____

Patient Medical History Date ____/____/____

Patient Name _____ DOB ____/____/____
Height: _____ Weight: _____
Pharmacy & Number: _____ Family Physician: _____

Reason for Doctor for Today's Visit: (Be specific):

_____

_____

Was this injury due to *work related* or an *auto accident* : Circle Which Applies ☐ Yes ☐ No

Date of your last A1C : (IF DIABETIC) _____ **LAST A1C:** _____

Answer each item to indicate your current and past medical conditions: CHECK YES OR NO

Diabetes	☐Yes ☐ No	Ulcers	☐ Yes ☐ No
High Blood Pressure	☐Yes ☐ No	Kidney disease	☐ Yes ☐ No
Shortness of breath	☐Yes ☐ No	Sinus	☐ Yes ☐ No
Lung disease	☐Yes ☐ No	Headaches/Migraines	☐ Yes ☐ No
Asthma/ Emphysema	☐Yes ☐ No	Thyroid disease	☐ Yes ☐ No
Poor circulation	☐Yes ☐ No	Hepatitis	☐ Yes ☐ No
Hernia	☐Yes ☐ No	HIV/Aids	☐ Yes ☐ No
Gastritis/Colitis	☐Yes ☐ No	Cancer	☐ Yes ☐ No
Diverticulitis	☐Yes ☐ No	Are you currently pregnant?	☐Yes ☐ No

List all of the **drug allergies** that you have, including **latex.** ☐ No known drug allergies
Allergic to:

_____

I hereby authorize T&U to electronically receive my medication history from other physicians Y N

List all of the **medications** that you currently take. ☐ Not currently taking medications
Medication and Dose

1._____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____

Tobacco Use? ☐Yes ☐ No ☐ Former smoker
Alcohol Use? ☐Yes ☐ No ☐ Former drinker

List all **surgeries and/or hospitalizations** that you have had and the year in which they occurred. ☐ No past surgeries ☐ No past hospitalizations

Surgery or Hospital Details	Date	Surgery or Hospital Details	Date
1. _____	____/____/____		
2. _____	____/____/____		
3. _____	____/____/____		
4. _____	____/____/____		

TIPTON & UNROE, PSC
Notice of Financial Responsibility

Thank you for choosing Tipton & Unroe, PSC for you health care needs. The patient financial policy has been developed to assist in answering questions regarding patient and insurance responsibility for services rendered. Your understanding of and compliance with our patient financial policy is important. Please read the policy below and ask the staff any questions you may have. If you have any questions regarding the policies below or your financial responsibility, please call the insurance department at (502)-447-4500.

Insurance

All patients must complete our patient information form before seeing the physician. It is your responsibility to ensure that we have your correct information and an up-to-date copy of your insurance card(s). Tipton & Unroe participates in most insurance plans, including Medicare. If we participate with your plan we will bill the insurance carrier directly and you will be responsible for co-payments, deductibles, non-covered services, etc. Please remember that your insurance coverage is a contract between you and your insurance company. Insurance policies often do not provide full payment of medical costs. Some services may not be covered or may not be considered reasonable or necessary by your insurance plan. Please contact your insurer directly for any questions regarding your coverage. Tipton & Unroe will file primary and secondary insurance only.

Updated Change of Information & Coverage

We will ask you to update this whenever you have a change in address, phone, or insurance. However, it is your responsibility to make us aware of these changes in a timely manner. If you fail to provide us with the correct updated information, you will be responsible for the entire cost of the services rendered and immediate payment will be expected.

Referrals

Insurance companies sometimes require their members to obtain a referral from their primary care doctor before seeing a specialist such as a podiatrist. It is your responsibility to obtain a referral if needed, and you must do so prior to your scheduled appointment or you will be forced to reschedule. We are unable, through contractual obligations with insurance carriers, to back-date referrals. Be aware that most referral authorizations are good for a certain number of visits and have an expiration date. If you have any questions about obtaining a referral we will be happy to assist you.

Patient Responsibility

All co-payments, deductibles, and co-insurance will be collected at time of service. This arrangement is part of your contract with your insurance company. A $20 processing fee will be charged for co-pays not collected at the time of service.

Non-Payment

If your account becomes more than 60 days past due, you will be required to pay your account in full within 10 days. Payment arrangements can be made with our billing office if you are unable to pay in full. If your account is not paid when due, you agree to reimburse us the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 33.3 % of the amount due at the time your account is placed with a collection agency. All costs and expenses incurred for any collection efforts on your account, including reasonable attorney's fees incurred by the collection agency. This contract shall cover all medical treatment and services until revoked by either party in writing.

Missed Appointments/Missed Procedures

If you must cancel an appointment, please give our office as much notice as possible so that we may allow other patients to utilize your appointment time. If your appointment is canceled less than 24 hours before your visit you will be charged a $25 missed appointment fee.

If you cancel a scheduled procedure such as nail removal, surgery consult ,or in office biopsy with less than 24 hours notice you will be billed a $50 procedure/missed appointment fee. In the event you cancel your surgery, Tipton & Unroe will retain $50 of your deposit to cover administrative costs. If you cancel with less than 48 hours notice you will be charged a $250 late cancellation fee, with the exception of medical clearance issues.

Payment Methods

We accept cash, personal checks, money order, MasterCard, Visa, Discover, American Express, PayPal, and Care Credit as payment for your services rendered. *We also offer Auto Pay by a secured link.*

Returned Checks

You will be charged a $40 returned check fee if a personal check is returned for non-payment.

Injuries

If you have been injured at work you must let the front desk know before you are taken back to see the physician. We need specific information to file a claim with workers compensation. **If you fail to notify us that a claim is workers compensation you may be held liable for all charges. It is your responsibility to notify the front office before being seen.**

I have read and understand the Notice of Financial Responsibility and agree to abide by its guidelines.

_____ _____

Signature of Patient or Responsible Party Date

Tipton & Unroe, PSC

Parental Consent

(Please Print)

Patient Name: _____ **DOB:** _____

We realize that parent and legal guardians may not always be able to personally bring their child to our office. However, state law dictates that a patient under the age of 18 cannot be treated without a parent or legal guardian present. If a parent or legal guardian cannot be present, then anyone authorized below can accompany the child and give consent for treatment. This form must be completed by a parent or legal guardian. Please inform your authorized person(s) that our staff will ask them for photo identification.

I, _____, the parent or legal guardian of _____, give consent for the following people to bring my child for treatment by Tipton & Unroe, PSC and its staff:

Authorized Person(s)	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Signature of Parent or Legal Guardian Date