Tipton & Unroe Foot and Ankle Care PSC
6801 Dixie Hwy Ste 134
Louisville, KY 40258
Phone: 502-447-4500 Fax: 502-995-7083

Last First Middle

Pt's Address Street City State Zip

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

Home Phone (____) _____ ____ Work Phone (____)_____

Mobile Phone (____)_____ Social Security: _____

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

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

Responsible Party: _____ _____ Relationship to patient: _____
RP Address: _____
RP Home #: _____ RP Work # & EXT: _____
RP Date of Birth ____/____/____ RP Sex: ☐Male ☐Female
RP SS # _____ RP Marital Status: ☐ M ☐ S ☐ D ☐ W
RP Employer's Name: _____
RP Employer's Address: _____
RP Occupation: _____

How did you hear about the office? ☐Referral (Who) _____ ☐Radio ☐TV ☐Yellow Pages ☐Internet ☐Other _____

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: _____
Print Name: _____

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 injury: ☐ Yes ☐ No

Answer each item to indicate **your** current and past medical conditions:

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		
Diverticulitis	☐Yes ☐ No	Are you currently pregnant?	☐Yes ☐ No

List all of the **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

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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. _____ ____/____/____

Summary Of Notice Of Privacy Practices

Uses and Disclosures of Health Information.
We will use and disclose your health information in order to treat you or assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization.
Except as stated in more detail in the Notice of Privacy Practices, we will not disclose your health information without your written authorization:

Uses and Disclosures Not Requiring Your Authorization.

- In the following circumstances, we may disclose your health information without your written authorization:
- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety
- To government agencies for purposes of their audits, investigations, and other oversight activities;
- To government authorities to prevent child abuse or domestic violence
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient rights. As our patient, you have the following rights.

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive a notice of our privacy practices.

Patient Portal Access.

Upon your request or consent, we will make your medical chart available to you via our patient portal located at **tiptonandunroe.com.** This site is maintained and supported by our EMR vendor. This portal will allow you to access your clinical summary, request an appointment, request refills on medications, see billing statements, and ask the doctors any questions you may have regarding your care.

***For further information on our Privacy Policies, please request a full copy at the time of your appointment.**

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 sent to an outside collection agency we will add a $75 processing fee to your balance and you will be discharged from the practice.

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