Foot and Ankle Specialists of MD, LLC
Dr. Michael Liebow, DPM, AACFAS

PLEASE FILL OUT ALL SECTIONS AND SIGN WHERE INDICATED ON ALL PAGES OF THIS FORM

Patient Information

Patient Name First: _____ Middle Initial: _____ Last: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

DOB: _____ Age: _____ Gender: M / F Marital Status: S / M / D / W / P

Social Security Number: _____

Email Address: _____

Primary Phone Number: _____ Work: _____Cell Phone: _____

Emergency Contact Name: _____ Phone: _____

Physician Information

Primary Physician Name (Required to process to Insurance): _____

Primary Physician Phone: _____

Last Visit to Primary Doctor (**REQUIRED FOR MEDICARE PATIENTS**):_____

Insurance Policy Holder Information
(REQUIRED TO PROCESS TO INSURANCE)

Policy Holder Name (**Not the name of your insurance**): _____

Policy Holder SSN (Required For Tricare Patients): _____ Policy Holder DOB: _____

Policy Holder Relationship to Patient: Self / Spouse / Dependent /Parent/ Other _____

Background Information

Language: English / Spanish / Russian / French / Other: _____

Race: White / Asian / Black or African American / Latino or Hispanic / American Indian / Alaska Native / Native Hawaiian or Pacific Islander

How did you hear about us? _____

Patient Release

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purposes of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDERS CURRENT RATE, MAY BE CHARGED ON ALL BALANCES owing to the provider that are past due.

I permit a copy of this to be used in place of the original.

Signature: _____ Date: _____

5225 Pooks Hill Road Suite 1B
Bethesda, MD 20814
Phone: 301.581.1111 Fax: 301.581.1131

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Patient Name: _____

Medications (Please list all): ☐ I currently take no medications ☐ _____

_____

_____

Pharmacy (Name and Street): _____ **Pharmacy Phone:** _____

Allergies: ☐No Known Drug Allergies ☐ Adhesive Tape ☐Aspirin ☐Codeine ☐Demerol ☐Erythromycin ☐ Local Anesthetics

☐ Penicillin ☐ Seafood/ Shellfish ☐ Sulfa Drugs ☐ Iodine ☐ Latex

☐ Other: _____

General: **Height:** _____ **Weight:** _____ **Shoe Size:** _____ **Width:** N / W / XW / XXW

Social History: Do you drink alcohol? YES /NO Amount: _____

Do you currently smoke? YES /NO Amount: _____

Have you ever smoked? YES /NO Amount: _____

Family History: Does/ has anyone in your family have or ever had any of the following? (CHECK ALL THAT APPLY)

☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Sickle Cell Disease ☐ Kidney Stones ☐ Mental Illness

Surgical History: (CHECK ALL THAT APPLY)

☐ Wisdom Teeth Extraction ☐ Tonsillectomy ☐ Thyroid ☐ Appendectomy ☐ Cancer ☐ Hernia ☐ Hip Replacement

☐ Knee Replacement ☐ Heart Surgery ☐ Biopsy ☐ Gallbladder ☐ Kidney Surgery ☐ Eye Surgery

☐ Other: _____

Medical History: Do you currently have or ever been treated for any items listed below? (CHECK ALL THAT APPLY)

☐ AIDS/ HIV ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Bleeding Problem ☐ Cancer ☐ Diabetes ☐ Epilepsy ☐ Fibromyalgia

☐ GERD ☐ Gout ☐ Headaches ☐ Heart Attack ☐ Heart Disease ☐ Hepatitis ☐ High Blood Pressure ☐ High Cholesterol

☐ Kidney Disease ☐ Liver Disease ☐ Lung Disease ☐ Lyme's Disease ☐ Osteoporosis ☐ Phlebitis/ Clots ☐ Poor Circulation

☐ Sciatica ☐ Stroke ☐ Stomach Ulcers ☐ Thyroid Problems ☐ Valve/ Joint Replacement ☐ Varicose Veins ☐ Venous Disease

☐ Other: _____

FOR OFFICE USE ONLY	**Input Into System By:**
Physician Initials:	**Date:**

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that a copy of the Notice of Privacy Practices is available to me upon request. I have read, or have had the opportunity to read them if I so choose and understood the Notice.

_____ _____
Patient Name (Please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Patient Signature

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Financial Policy for Foot and Ankle Specialists of Maryland, LLC

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up to date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES: Copayments may either be paid in the office at time of service or processed out through our billing agency and you will receive a statement at a later date.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance or your visit is not covered by Medicare.

NON-COVERED SERVICES: Please be aware that some of the services that you may receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan, which may mandate that when you visit a specialist such as us, you have a referral from your primary care physician prior to seeking specialty care. Therefore, if a referral is required, you are financially responsible for the services received, unless your referral is presented at the time of the visit. If you do not have a referral from your primary care physician at the time of the visit, you will be financially responsible for all services received due in full upon completion of the visit. It is not the responsibility of our office to obtain referrals for patients.

CLAIM SUBMISSIONS: As a courtesy service to you, we will submit your insurance claims for services rendered in our office and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or Explanation of Benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to a Collections Agency and you will be responsible for any and all fees included. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check, Visa/MasterCard/Discover/American Express. An additional $35.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you forward it to our office to be applied to your balance, otherwise you will be billed and responsible for the balance.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

ASSIGNMENT OF BENEFITS: I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Foot and Ankle Specialists of Maryland, LLC all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize Release of Medical Information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I have read the above policy regarding my *financial responsibility* to Foot and Ankle Specialists of Maryland, LLC for medical services provided. I agree to pay Foot and Ankle Specialists of Maryland, LLC any balance unpaid by my insurance carrier for myself or the below named person.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and/or contact information and acknowledge that I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms.

PRINT Patient Name: _____ **Signature:** _____

Financially Responsible Party: _____ **Signature:** _____

Relationship to Patient: _____ **Date:** _____

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Foot and Ankle Specialists of MD, LLC
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Appointment Policy for Foot and Ankle Specialists of Maryland, LLC

Dr. Liebow and the staff at Foot and Ankle Specialists of Maryland are committed to providing high quality care, both efficiently and with compassion.

A doctor/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your scheduled appointments, and ask that you give us the courtesy of a call when you are unable to keep an appointment.

Due to an increasing number of patients being consistently late, canceling with little notice, or not showing up to their scheduled appointments we have been forced to implement a new policy that will involve a fee that is *not* covered by insurance and will be your financial responsibility.

In order to be respectful of the medical needs of other patients, please be courteous and call Foot and Ankle Specialists of Maryland promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call **at least 24 hours** in advance, and calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

Reminder Phone Calls

It is your responsibility to know when your appointment is. You are given an appointment card for your visit. Due to Dr. Liebow's practice continually growing, **courtesy reminder calls will no longer be made**. We apologize if this causes any inconveniences for you.

Definitions:

Missed Appointment/ "No Show": A missed appointment or "no show" is when you fail to show up for an appointment without a phone call, cancel without at least 24-hour notice or you are 15 minutes or later to your appointment. **(If you arrive 15 minutes or later, your appointment will be rescheduled and you will not be seen.)**
Routine Visit: An initial visit or a follow-up visit not involving an in-office procedure or post- operative treatment.
Office Procedures/ Post- Operative Visit: A visit that consists of an in-office procedure (wart, ingrown nail, etc.) or a follow up from an in-office procedure or a surgery done at the hospital.

As of October 1, 2012, the new policies are as follows.

Routine Office Visits

1. **1st Missed Appointment**: *You will be charged a missed appointment fee of $25.00.*
2. **2nd Missed Appointment:** *You will be charged a missed appointment fee of $25.00.*
3. **3rd Missed Appointment:** You will be charged a missed appointment fee of $25.00. *This may result in a discharge from the practice.*

Office Procedure/ Post- Operative Visits

1. 1st Missed Appointment: *You will be charged a missed appointment fee of $40.00.*
2. 2nd Missed Appointment: *You will be charged a missed appointment fee of $40.00*
3. 3rd Missed Appointment: You will be charged a missed appointment fee of $40.00. *This may result in a discharge from the practice.*

Let's work together to provide you with the best possible care you deserve.

I have read and understand the Appointment Policy for Foot and Ankle Specialists of Maryland.

Patient or Responsible Party Signature: _____ **Date:** _____

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