William D. Fishco, DPM, PC
Diplomate, American Board of Foot and Ankle Surgery

Last Name	First Name	Middle Initial

Street Address	City	State	Zip Code

Home Phone #	Cell Phone #	**Circle** preference for contact. Home/Cell	**Circle** preference for reminders. Text/Phone call.

Birth Date	Age	Gender	Race/Ethnicity	Email Address

Preferred Pharmacy	Emergency Contact	Relationship	Phone #
-- ❏ Consent to check Online Med List			

Insurance Information - Please bring your card(s) to our office

Insured Employer	Insured Date of Birth	Relationship to Insured

Primary Insurance	Secondary Insurance

Referred to Dr Fishco by:____

⇛ Authorization for Assignment benefits to Dr. Fishco **Patient Signature** X___________________________

⇛ HIPPA Authorization (Privacy) **Patient Signature** X_____________________________________

Name	Date of birth

Height	Weight	Shoe Size	Current smoker? Y / N Former Smoker? Y / N Years smoked ________	Drink Alcohol? Y / N If Yes ______drinks/week

Allergies/Reactions To Medications:	**Check here if NONE_______**

Reason for Evaluation/Treatment ❑ Left Description: ❑ Right	How long?	Prior Treatment? Y/ N By Dr.______________

Past Surgical History (Entire Body)	❑ Check here if NONE

Primary Care Physician (PCP):	❑ Check here if NONE

Check/Circle all conditions that apply to either the **PAST or PRESENT**:

- ❑ Artificial Joints
- ❑ Asthma
- ❑ Cancer (Type:__________)
- ❑ Chemotherapy
- ❑ Circulation problems in legs
- ❑ Depression/Anxiety
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Problems (Attack/Murmur/Irreg. beat/Congestive heart/Mitral Valve)
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ HIV/AIDS
- ❑ Kidney problems (Infections/Stones/Dialysis)
- ❑ Liver problems
- ❑ Lung/breathing problems
- ❑ Neurological problems
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Prostate problems
- ❑ Psoriasis/Eczema
- ❑ Rheumatoid Arthritis
- ❑ Stomach Ulcer/GERD
- ❑ Stroke
- ❑ Substance Abuse
- ❑ Thyroid problems
- ❑ Varicose Veins
- ❑ Other: ___________________

Signature:____Date:_____________________

WILLIAM D. FISHCO, D.P.M., P.C.
Diplomate, American Board of Podiatric Surgery
Fellow, American College of Foot and Ankle Surgeons

Patient Name: ____

PATIENT MEDICATION LIST

MEDICATION	DOSE	FREQUENCY

Check here if none ☐

WILLIAM D. FISHCO, D.P.M., P.C.

41818 N. Venture Drive, Suite 110, Anthem, AZ 85086

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for William D. Fishco, D.P.M. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have a right to review the Notice of Privacy Practices prior to signing this consent. William D. Fishco, D.P.M. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to William D. Fishco, D.P.M. Privacy Officer at 41818 N Venture Dr #110, Anthem, AZ 85086.

With this consent, William D. Fishco, D.P.M. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, William D. Fishco, D.P.M. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, William D. Fishco, D.P.M. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that William D. Fishco, D.P.M. restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to William D. Fishco, D.P.M. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, William D. Fishco, D.P.M. may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

______________________________________ ____________________
Print Patient's Name Date

____
Print Name of Legal Guardian (if applicable)

Patient Financial Agreement

Dear Patient:

We would like to take this opportunity to welcome you to our practice and thank you for choosing William D. Fishco, D.P.M., P.C. to provide your foot and ankle care. We appreciate your trust and look forward to keeping your feet healthy.

As part of your service, we try to contain the rising cost of healthcare. In an effort to do this, we have implemented this Financial Policy which we ask you to read and sign. You may receive a copy for your records if you so desire.

INSURANCE BENEFITS AND COVERAGE

As a courtesy to you, our billing service (J&S Billing Services, LLC) will submit your insurance claim(s) for treatment rendered at this office. Please be advised that your insurance policy is a contract **between you and your** insurance company. We **are not** a party to that contract. If you ever have any questions regarding your coverage and /or benefits, please contact your insurance company. Ultimately, you are responsible for all costs incurred during treatment with the exception of insurance contracted adjustments. These adjustments are determined by the contract with the doctor and the insurance company. If your insurance does not accept assignment of benefits, in other words, if they pay you rather than the doctor, payment must then be made in full at the time of service. In such instances, we will submit the claim on your behalf.

COPAYMENTS, DEDUCTIBLES, AND COINSURANCE

Although we do accept assignment of insurance benefits, we require payment of any copayments due at the time of service. **We accept cash, credit/debit cards.** If you have any deductible or coinsurance amounts to be met, you will be billed once your insurance has processed and paid their portion of the claim.

UNISURED PATIENTS AND NON-COVERED BENEFITS

Full payment is due at the time of service. **We accept cash, debit, and credit.** In some instances a payment plan may be made for some patients on a case-by-case basis with our billing service. While we try to accommodate all of our patients, our billing service does maintain strict guidelines regarding payment plans.

BALANCE AND STATEMENT

You will receive a statement once a month only if you have a balance owing. **Failure to pay a balance by the third billing statement will result in your account being turned over to "collection status."** The doctor will no longer be able to continue treatment until the balance is paid or special payment arrangements are made. **Please note that there is a $25 fee plus balance on all returned checks.**

In order to refrain from raising our fees, we must control our costs and maintain efficiency in the business aspect of our practice. We are dedicated to providing you and your family with the best possible podiatric care. We will also attempt to accommodate you whenever possible. If you have any questions, please contact our office and we will be happy to discuss them with you. Thank you for your understanding.

I have read the Financial Policy and understand and agree to its terms.

____

Signature of patient or parent if a minor   Date