MIDWEST ORTHOPEDICS FOOT & ANKLE, P.A.

Susan K. Bonar, M.D.
11237 Nall Ave Suite 130
Leawood, Kansas 66211
913-469-3690

Patient Information:

Last Name: ________________________ First Name: ________________________ MI: ____

Street Address: ___________________________Email Address:____________________________

City: ________________________________ State: __________________ Zip: ______________

Home Phone: ______________ Mobile Phone: _______________ Work Phone: ______________

Date of Birth(mm/dd/yyyy): _________________ SSN: ________________________________

Sex: ❑M ❑F Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed

If patient is a minor, responsible party information:

Last Name: ________________________ First Name: ________________________ MI: ____

Street Address: ____

City: ________________________________ State: __________________ Zip: ______________

Home Phone: ______________ Mobile Phone: _______________ Work Phone: ______________

Date of Birth(mm/dd/yyyy): _________________

Sex: ❑M ❑F Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed

Employment Information:

Status: ❑Employed ❑Unemployed ❑Disabled

Employer Name: ____

Occupation: ____

Physician Information:

Referring Physician Name: _____________________________ Phone: _____________________

Primary Physician Name: _______________________________ Phone: _____________________

If no referring physician, how did you hear about Dr. Bonar? ______________________________

____

____

PRIMARY INSURANCE:

Name of Insurance Company: ____

Policy Number: ____________________________Group Number: ________________

****IF THE SUBSCRIBER IS NOT THE PATIENT**:

Subscriber Name: ____

Subscriber's Date of Birth: ____

SECONDARY INSURANCE:

Name of Insurance Company: ____

Policy Number: ____________________________Group Number: ________________

****IF THE SUBSCRIBER IS NOT THE PATIENT**:

Subscriber Name: ____

Subscriber's Date of Birth: ____

MEDICARE PATIENTS ONLY:

I hereby authorize payment of my Medicare and benefits to Midwest Orthopedics Foot & Ankle, P.A. for all claims filed on my behalf. This authorization applies to all services until it is revoked by myself or my representative.

Patient Signature: ____

Medicare Number: ____

PATIENT FINANCIAL POLICY

Midwest Orthopedics Foot & Ankle, P.A. ("MOFA") wants to thank you for choosing Dr. Bonar for your orthopedic needs. It is the patient's responsibility to provide their most current demographic and insurance information at each visit. If your insurance denies coverage, you will be personally responsible for payment of MOFA's charges. If you are not covered under any insurance, you may be accepted as a "self-pay" and pre-payment is required.

Patient Balances: Outstanding balances are due when you receive your statement or at your next visit, whichever is sooner.

Co-Payments: Your co-pay is due at each visit prior to seeing the doctor.

Referrals: If your insurance plan requires a referral from your Primary Care Physician, it is the patient's responsibility to call their insurance company and obtain any required referrals prior to their appointment. Failure to obtain required referrals may result in your insurance company denying coverage or paying only out-of-network benefits. You will be responsible for all MOFA charges not covered by your health insurance.

In-Network/Out-of-Network: It is the patient's responsibility to determine whether Dr. Bonar is in or out of network for their insurance policy. Patients will be responsible for any charges not covered by their insurance as a result of Dr. Bonar not being in network.

Motor Vehicle Accident/Personal Injury Claims: Prior to your appointment, you must notify MOFA if your injury is the result of a Motor Vehicle Accident or Personal Injury involving a potentially liable party. If you injury is the result of such an event you will be considered self-pay and pre-payment is required prior to seeing Dr. Bonar. If we are not informed of the accident you will be personally responsible for all MOFA charges denied or "taken-back" by your health insurance.

Workers Comp Claims: Prior to your appointment, you must notify MOFA if your injury is a result of a work-place injury. Your employer, workers compensation insurance company, or attorney must authorize your treatment in writing before your appointment.

Disability/FMLA/Insurance etc. Forms: To cover the costs of our staff's labor, completion of each form requires a prepayment of $25.00 for the first page and $5.00 for each additional page. Please allow 7-10 business days from receipt of the prepaid fee for the forms to be completed.

Medical Records: MOFA charges $25.51 (base fee) plus $0.59 per page. MOFA charges $5.00 per x-ray to cover costs of supplies and labor. All charges must be prepaid. Please allow 7-10 business days from receipt of the prepaid charge for medical records to be available to pickup/fax/send. Copies of x-rays cannot be faxed.

Cam (Walker) Boots, Night Splints, Cast Covers: Walker boots and night splints are often not covered by health insurance. For this reason, we charge $85 for cam boots and $60 for night splints – payment is due at check-out. We will submit claims to your insurance company for walker boots and night splints. If your insurance company pays for the boot or night splint we will apply your payments to any outstanding patient balances and send you a refund if there is any remainder.

Returned Check Fee: Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being charged a $25.00 fee per check returned.

By signing below you attest that you have read and fully understand MOFA's Patient Financial Policy. If you do not make payment for services owed, MOFA will take all necessary and appropriate action to collect any money due on your account, but not limited to the use of collection agencies or attorneys. You will be responsible for any and all fees associated with these collection efforts.

Signature of Patient/Guardian: ____________________________ Date: ______________________

Printed Name of Patient/Guardian: ________________________________

Consent to Use and Disclosure of Protected Health Information for Purposes of Treatment, Payment, and Health Care Operations

As a condition of providing treatment to you, Midwest Orthopedics Foot & Ankle PA, obtains your consent to use and disclose protected health information about you to carry out treatment, payment, and the health care operations of Midwest Orthopedics Foot & Ankle PA.

You may revoke this at any time by notifying Midwest Orthopedics Foot & Ankle PA, in writing, except to the extent Midwest Orthopedics Foot & Ankle PA, has taken action and reliance on your consent.

Your protected health information may be used and disclosed to carry out treatment, payment, or health care operations.

Please refer to the Notice of Privacy Practices for Protected Health Information ("Privacy Notice") for a more complete description of the uses and disclosures that Midwest Orthopedics Foot & Ankle PA, may use of your protected health information. You have the right to review the Privacy Notice prior to signing the consent.

Midwest Orthopedics Foot & Ankle PA has reserved the right to change its privacy practices described in this Privacy Notice. In accordance with law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.

You have the right to request Midwest Orthopedics Foot & Ankle PA to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. Midwest Orthopedics Foot & Ankle PA is not required, however, to agree to such requested restrictions. If, however, Midwest Orthopedics Foot & Ankle PA agrees to the requested restriction, Midwest Orthopedics Foot & Ankle PA will honor the request and it will be binding on Midwest Orthopedics Foot & Ankle PA.

I hereby consent to the use and disclosure by Midwest Orthopedics Foot & Ankle PA, its workforce, and its business associates of my protected health information for purposes of treatment, payment, and health care operations.

___Yes ___No Employees of Midwest Orthopedics Foot & Ankle PA may leave confidential information regarding scheduling, test results, or other information requested by me on my answering machine or voice mail.

___Yes I have received a copy of the Notice of Privacy Practices for Protected Health Information from Midwest Orthopedics Foot & Ankle PA.

____

Signature

____

Signature of Personal Representative of Patient

____

Description of Representative's Authority to Act for Patient

____

Date

MIDWEST ORTHOPEDICS FOOT & ANKLE, PA

Date: ________________________

Name: ____ Age: ______________
Name of Doctor or Person who referred you? ____

CHIEF COMPLAINT:
What are we seeing you for today (i.e. right heel pain, left foot pain, ankle pain)? ________________________

HISTORY OF PRESENT ILLNESS:
Was this an injury or accident or did it start gradually? ____

If this is an *injury* or *accident*:
In what state did the injury or accident occur? ____
Where did the injury occur (i.e. work, home, church)? ____
How did it happen? ____
When did it occur? ____
Where were you initially (i.e. St Joseph's Emergency Room)? ___________________________________
How were you treated (i.e. x-rays, splint, pain meds, crutches, ice elevation, other)? __________________
____

If this came on *gradually*, or since the injury, how have you been treated? _____________________________________
(i.e. x-rays, inserts, shots, physical therapy, non-steroidal medication)

Have any special test been done?
- ❒ Bone scan, results: ____
- ❒ MRI, results: ____
- ❒ CT scan, results: ____

How long has this been going on (i.e. 1 week, 3 months, 4 years)? ____

Do you have pain daily? ❒ Yes ❒ No
Does it cause you to limp? ❒ Yes ❒ No
Does it keep you from doing things you enjoy? ❒ Yes ❒ No
Such as (i.e. golfing, walking)? ____
When does it hurt the most (i.e. first thing in the morning, throughout the day, at night? ________________________

Do you have: ❒ Swelling ❒ Locking or Catching ❒ Giving way? (Check all that apply)
Does it wake you up at night or keep you awake? ❒ Yes ❒ No
What aggravates it? ❒ Standing ❒ Walking ❒ Sitting ❒ Other ____________________________________
What makes it feel better? ❒ Elevation ❒ Ice ❒ Wraps ❒ Staying off it ❒ Other ____________________

Have you had any previous surgeries or injuries of this body part? ❒ Yes ❒ No
If yes, please explain: ____
____

Do you do any regular exercise? Yes/No, If you please explain:
- ❒ Stair stepper/ stair master
- ❒ Walking: How often? ________________________________ How far? __________________________
- ❒ Running: How often? ________________________________ How far? __________________________

Physician Signature: ________________________

Midwest Orthopedic Foot & Ankle, PA

PAST MEDICAL HISTORY

Name: ______________________________ Age: _______ Date: _____________

List all past operations *Year* *Outcome*

____
____
____
____

Do you have a history of:

Heart Disease	YES ❑	NO ❑
Cancer	YES ❑	NO ❑
Diabetes	YES ❑	NO ❑
Bleeding Ulcer	YES ❑	NO ❑
Blackout/Fainting	YES ❑	NO ❑
Epilepsy	YES ❑	NO ❑
Digestion/Stomach	YES ❑	NO ❑
Rheumatoid Arthritis	YES ❑	NO ❑
Polio	YES ❑	NO ❑
TB	YES ❑	NO ❑
AIDS	YES ❑	NO ❑
Hepatitis	YES ❑	NO ❑

Do you have problems with:

Lungs/Breathing	YES ❑	NO ❑
Stomach Problems	YES ❑	NO ❑
High Blood Pressure	YES ❑	NO ❑
Bleeding/ Blood clots	YES ❑	NO ❑
Eyes	YES ❑	NO ❑
Ears/Nose/Throat	YES ❑	NO ❑
Bowel movement	YES ❑	NO ❑
Bladder	YES ❑	NO ❑
Numbness/Tingling	YES ❑	NO ❑
Balance	YES ❑	NO ❑
Psychological	YES ❑	NO ❑
Other ___________________________		

Please explain if you checked yes to anything above: ___________________________________
____
____

Please list all medications you are currently taking:

Medicine **Dose** **Frequency** **For what illness**

____
____
____

Do you have a latex allergy? YES ❑ NO ❑

List any allergies to medications or food and adverse reactions:

____
____

Do you smoke? YES ❑ NO ❑ How many cigarettes per day? ____________________

Do you drink alcohol? YES ❑ NO ❑ How many drinks per week? ______________________

Has any family member had a history of serious illness? YES ❑ NO ❑

If yes, please describe: ____

Has any member of your family been seen in our office before? YES ❑ NO ❑

If so, who? ____

Occupation: ____

How long have you worked there? ____

Physician's Signature: ____________________________________