MOUNTAIN VIEW
FOOT & ANKLE CLINIC

Welcome to our practice! Please complete new patient intake forms to confirm your appointment

Feel free to call anytime with any questions or concerns.

LEHI LOCATION
2183 W MAIN STREET SUITE A103
LEHI, UT 84043

PHONE: 801-784-1111
FAX: 866-237-5042
EMAIL:
MOUNTAINVIEWFOOTCLINIC@GMAIL.COM

NAME DOB DATE

ADDRESS CITY ZIP

HOME PHONE CELL

SEX ☐ M ☐ F MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

OCCUPATION

EMERGENCY CONTACT PHONE

PRIMARY INSURANCE ID#

SECONDARY INSURANCE ID#

Preferred Pharmacy & approximate address:

How did you hear about the practice? (circle one)

Internet/Google_____ Friend/Family_____
Doctor Referral (who?)_____ Insurance Company_____
Facebook_____ Other_____

What is the reason for your visit today?

Height Weight Shoe Size

Athletic activities in which you participate:

Medical History: please check off if you have any of the following

☐ Liver	☐ High cholesterol	☐ Allergies	☐ Breathing issues
☐ Heart Murmur	☐ Blood disorders	☐ High Blood Pressure	☐ kidney disease
☐ Blood clot	☐ Gout	☐ Heart Disease	☐ Hepatitis
☐ Neuropathy	☐ Depression	☐ Mental illness	☐ Stroke
☐ Arthritis	☐ Thyroid disorder	☐ Cancer	Other:
☐ Alcoholism	☐ circulation problems	☐ Diabetes	

Allergies: please check off or list allergies

☐ Adhesive/Tape	☐ Demerol	☐ Novocaine	Other
☐ Aspirin	☐ Iodine	☐ Penicillin	
☐ Codeine	☐ Local Anesthetics	☐ Sulfa	

Please list all surgeries you have had in the last 5 years

Medications:

Are you pregnant? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No Do you drink alcohol ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

Consent : I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient Signature: Date:

Mountain View Foot Clinic office and financial policies

Thank you for choosing Dr. Steven Royall as your healthcare provider. Your understanding of our Financial Policy is important to our professional relationship. Please contact one of our Patient Account Representatives at (801) 784-1111 to address any questions or concerns you may have about our fees,financial responsibility, and office policies.

Your Financial Responsibilities

Remember your insurance is a contract between you and your insurance company. You are ultimately responsible for the payment of your account. Our practice will file insurance claims to your primary and secondary insurance carriers once you have provided us with all the necessary information. Please note that you are responsible for payment of all co-payments, co-insurance, deductibles, and non-covered services at the time of the visit. No shows and cancellations with less than 24 hours notice will be automatically charged a $50 no show fee. We accept payment by cash, Visa, MasterCard, Discover, and American Express. You will receive statements for account balances that are your responsibility. If payment is not received in a timely manner, collection efforts will be made. Any collection agency fees or other expenses incurred to collect will be at your expense.

Health Insurance

Our practice participates with many private insurance plans. It is your responsibility to know your plan coverage, know who the eligible providers are for your plan, and to meet your financial obligations as a policy holder. As a courtesy, we will submit a claim on your behalf and make every effort to resolve any billing problems that may arise. If your plan requires a co-payment, we will collect it at the time of service. Please be prepared to pay this at each visit, or your appointment may be rescheduled. **Referrals & Pre-Authorization**: It is your responsibility to obtain any required referrals or pre-authorization required by your insurance. Please notify our office staff if this is required and they may assist you.

Workers Compensation

It is your responsibility to notify your employer of a work-related injury to initiate a work comp claim. In addition, you must provide us with the name of the work comp insurance company, name & phone number of the case manager or adjuster, claim number, date of injury, and description of injury. All services provided to patients under a work comp claim must have services pre-authorized by the insurance carrier.

Accidents

It is your responsibility to file a liability insurance accident claim if you are injured as a result of an accident. If you believe you are eligible for benefits from a liability insurance company, you must provide us with the name of the insurance company, name of the policy holder, name & phone number of the agent or adjuster, date of the accident, and claim number. Ultimately, you are responsible for payment of all services rendered as a result of an accident. As permitted by law, we will lien patient recoveries from any legal or insurance settlement for unpaid charges.

Self-Pay (No Insurance Coverage)/High Deductible Insurance Photography

If you do not have insurance, payment in full is due at time of service

Photography

It is the policy of Mountain View Foot Clinic to noy allow still photography or video recordings in the office on any procedure performed while at Mountain View Foot Clinic.

Non-Covered Services/ Products

Dr Royall often prescribes or dispenses non-covered products or performs non-covered services. It is our office policy to not bill your insurance for these products or services. He frequently prescribes custom functional orthotics to treat chronic foot and ankle conditions. It is the policy of this office NOT to bill your insurance carrier for custom orthotics; therefore, you will be required to pay half the cost of the orthotics at the time of casting and the balance of the orthotics at the time of dispensing. If you elect to seek reimbursement from your insurance carrier, we will **NOT** reimburse any of the money paid to this office. If your insurance deems the orthotics to be a plan benefit and reimbursement is acknowledged, your insurance carrier will reimburse you directly. If any reimbursement is made by your insurance carrier, it may be less then what was paid to the office. Office visits related to these appointments will be billed to your insurance company.

Acknowledgement

I have read, understand, and agree to the policies of Dr. Steven Royall. I understand that any charge not covered by my insurance company, as well as applicable copayments, deductibles, and coinsurance is my responsibility.

_____ _____

Signature of Patient or Responsible Party Date

HIPAA & AUTHORIZATION AND CONSENT TO TREATMENT

Assignment of Benefits and Authorization to Release Medical Information: I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize Mountain View Foot Clinic to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay them directly, I agree to forward to Mountain View Foot Clinic all health insurance payments which I receive for the services rendered by Mountain View Foot Clinic and its health care providers. I authorize Mountain View Foot Clinic or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my insurance plan does not participate or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification: In consideration of the services provided by Mountain View Foot Clinic and its providers, I agree that I am responsible for all charges for services provided not covered by my health insurance plan. I agree to pay all charges not covered by my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse Mountain View Foot Clinic's expenses and attorney's fees incurred to collect those charges. If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions.

Consent to Treatment; I voluntarily consent to the rendering care and treatment by Dr. Royall by his professional judgment, deem necessary for my health and well-being. My consent shall cover medical examinations,diagnostic testing , injections,xray, ultrasound and surgical procedures. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any care center staff have made any guarantee or promise as to the results that may be obtained.

Consent to Call, Email & Text: I understand and agree that I may be contacted using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications. I understand that I may optout of receiving such communications by notifying Chelsea at mountainviewfootclinic@gmail.com.

HIPAA: I understand that Mountain View Foot Clinic's Privacy Notice is available at royallpodiatry.com and that I may request a paper copy at the reception desk.

I hereby acknowledge that I have received Mountain View Foot Clinics Financial Policy and Notice of Privacy Practices. I agree to the terms of the Financial Policy. This form and assignment of benefits applies and extends to subsequent visits and appointments with Mountain View Foot Clinic.

Printed Name of Patient: _____

Signature: _____Date: _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent