Ankle and Foot Specialists of Marion

PATIENT DEMOGRAPHIC INFORMATION -
Please Complete This Entire Form. Thank You!

Today's Date: _____/_____/____ **Referred By *(If Applicable)*: _____**

OFFICE USE MRN: _____

PATIENT INFORMATION

LAST NAME:	**LEGAL FIRST NAME:**	**MIDDLE INITIAL:**	**DATE OF BIRTH *(mm/dd/yyyy)*:**
PREFERRED NAME:	**HOME PHONE:** ( )	**CELL PHONE:** ( )	**PRIOR NAME(S):**
SEX: □ **Male** □ **Female** □ **Unknown**		**MARITAL STATUS:** □ **Single** □ **Married** □**Divorced** □**Widowed** □ **Separated**	
MAILING ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
PHYSICAL ADDRESS *(If different from mailing address)*:	**CITY:**	**STATE:**	**ZIP:**
Preferred Pharmacy:	**Pharmacy Telephone:** ( )		
E-MAIL ADDRESS: □ **None** □ **Prefer Not to Disclose**	**USE E-MAIL ADDRESS FOR PATIENT PORTAL:** □ **Yes** □ **No** □ **Not Applicable**	**SOCIAL SECURITY #:**	
RACE: □ **American Indian/Alaskan Native** □ **Asian** □ **Black/African American** □ **Native Hawaiian/Other Pacific Islander** □ **White** □ **Refuse to Report** □ **Other**			
PREFERRED LANGUAGE: □ **English** □ **Spanish** □ **Other (*please specify*):** **Translator Needed:** □ **Yes** □ **No**		**ETHNICITY:** □ **Hispanic/Latino** □ **Non-Hispanic/Latino** □ **Refuse to Report**	
CURRENT LEVEL OF CARE: □ **Hospice** □ **Permanent Nursing Facility (Long Term Care, Memory Care Unit) Facility Name:** □ **Not Applicable**			

EMERGENCY CONTACT

LAST NAME:	**FIRST NAME:**	**RELATIONSHIP *(Please specify)*:**
HOME PHONE: ( )	**CELL PHONE:** ( )	**MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL:** □ **Yes** □ **No**

PLEASE CONTINUE ON THE BACK SIDE OF THIS FORM

ADDITIONAL CONTACT (OPTIONAL)

LAST NAME:	FIRST NAME:	RELATIONSHIP *(Please specify)*:
HOME PHONE: ( )	CELL PHONE: ( )	MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: □ Yes □ No

EMPLOYER INFORMATION

EMPLOYER NAME:	EMPLOYER PHONE NUMBER: ( )
EMPLOYMENT STATUS: □ Employed □ Full Time □ Part Time □ Retired □ Self Employed □ Unemployed □ Active Military □ Student	

INSURANCE INFORMATION

(Please present all current insurance cards to the Front Desk)

I HAVE INSURANCE: □ Yes □ No *(Self Pay)*			
PRIMARY INSURANCE:		SECONDARY INSURANCE:	
SUBSCRIBER:	RELATION:	SUBSCRIBER:	RELATION:
DATE OF BIRTH *(mm/dd/yyyy)*:	SOCIAL SECURITY #:	DATE OF BIRTH *(mm/dd/yyyy)*:	SOCIAL SECURITY #:

CONFIDENTIAL COMMUNICATION

(I hereby request to receive confidential communications from AFSM in the following manner)

TELECOMMUNICATIONS –Please leave messages regarding my protected health information as follows (*Check Preferred*):	POSTAL COMMUNICATIONS –Please mail my protected health information to me at (*Select One*):
□ Home Phone of Record □ Brief □ Extended □ Cell Phone of Record □ Brief □ Extended □ Work Phone of Record □ Brief □ Extended Example of Extended: Lab Results Example of Brief: Time/Day of Appointment	□ Mailing Address of Record □ Street Address of Record □ Other:_____

ADVANCE DIRECTIVES

DO YOU HAVE A LIVING WILL? □ No □ Yes
(If yes, please provide a copy to the Front Desk)
DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE? □ No □ Yes
(If yes, please provide a copy to the Front Desk)
DO YOU HAVE A DO NOT RESCUSITATE? □ No □ Yes
(If yes, please provide a copy to the Front Desk)

HOW DID YOU HEAR ABOUT US?

□ Community Event □ Our Website □ Facebook □ Health Plan Website □ Internet Search □ Online Reviews
□ Outdoor/ Billboard Advertisement □ Print Advertisement
□ Referred by Physician_____ □ Referred from Friend/Family □ Other_____

PRIMARY CARE PROVIDER:

Primary Care Provider:	PHONE NUMBER: ( )

_____ _____ _____
Patient Printed Name | Patient Signature | Date Signed

_____ _____ _____
Legal Guardian Printed Name (*if applicable*)* | Legal Guardian Signature (*if applicable*)* | Date Signed

Ankle and Foot Specialists of Marion

Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card. Adult patients or the adult signing for a dependent patient is responsible for their bill being paid in full. Upon your initial visit and some future visits you will be asked to provide a photo ID. Please inform us at every visit of any changes to your insurance coverage, your address or phone number and provide us with your most recent insurance card.

-COPAYMENTS: It is a requirement of your insurance company that we collect your co-pay at every visit. Payment is required before meeting with the doctor.

-DEDUCTIBLES & COINSURANCE: If you have not met your yearly deductible amount with your insurance plan, we may collect a **$125** deposit to apply towards your deductible and coinsurance. Any remaining balance after submission to your insurance company is your responsibility.

-SELF-PAY (for non-covered products and services and for patients without insurance coverage): Full payment is due at time of service. Payment for evaluation and management services at minimum will be required before seeing the doctor. Additional procedures/services may be recommended by the doctor. You will be informed of these charges before proceeding with treatment.

-REFERRAL: If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we will need to reschedule your appointment.

-NO SHOW(failure to present for your appointment): 24 hours-notice is required for cancellation of your appointment and failure to do so will incur a **$25** fee. Failure to provide **24 hours-notice** for a scheduled office procedure will incur a **$50** fee.

-SURGERY CANCELLATION: Failure to provide **5 business-days'** notice before surgery may incur a fee up to **$500**.

-BALANCES/COLLECTION FEES: If you have questions about your bill or balance, you can call our office at: 740-383-5115 and follow the prompts for billing. Our practice offers the ability to submit payments conveniently and securely online at our website: Patients with balances more than 90 days overdue will be turned over to collections and a **$35** administrative fee will be applied.

-FMLA/DISABILITY/MEDICAL RECORDS: There is a **$40** charge for having the doctor complete these forms. Requested forms will be completed within five business days of request.. There is a fee to obtain a copy of your medical records. Our staff will let you know the amount after they calculate the fee based on fee schedules in place by the State of Ohio.

My signature below indicates that I have read and understand the financial policies described above.

Patient Name (print): _____

Patient/Responsible Party Signature:_____ Date: _____/_____/

_____ *Revised: 12/31/25*

Ankle and Foot Specialists
of Marion
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Ankleandfootspecialistsmarion.com

CONSENT FORM FOR PHOTOGRAPHY/VIDEO-TAPING OR OTHER IMAGING FOR MEDIA OR EDUCATION PURPOSES

Patient's Name_____ Patients Date of Birth_____

___ I give consent to have photographs, videotaped images, or other images of my foot/feet, ankle(s), or lower leg(s). I understand and agree that these images may be used by Ankle and Foot Specialists of Marion Inc. for any purpose listed below:

Teaching purposes, which includes being shown to other patients
Advertisements by Ankle and Foot Specialists of Marion, Inc
Placement on Ankle and Foot Specialists of Marion, Inc website

OR

___ I decline the above consent for photography/video-taping, or other images

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TCPA (Telephone Communication Protection Act) Consent Form

Patient's Name_____ Patients Date of Birth_____

I _____, Agree that Ankle and Foot Specialist of Marion Inc. may contact me by telephone at any of the telephone numbers associate with your account, including wireless telephone numbers which could result in charges by your phone carrier. We may also contact you by sending text messages or emails, using the wireless number and email you provided us with. Methods of contact may include using pre-recorded, artificial voice messaging and/or the use of automatic dialing device, as applicable. I have read this disclosure and agree that Ankle and Foot Specialists of Marion, Inc may contact me as described.

_____ _____
Signature of patient/legal guardian Date

Revised: 12/12/25