



G. Adam Shapiro, DPM, FACFAS
*Diplomate, Am. Board of Podiatric Surgery
Board Certified in Foot Surgery*
Matthew C. Liwski, DPM
*Podiatric Foot & Ankle Surgeon
Specializing in Lower Limb
Reconstructive Surgery*

Thank you for choosing Dr. Shapiro, Dr. Liwski and the wonderful staff of Foot & Ankle Associates.

Since 1998, Foot & Ankle Associates has been here to provide the best possible medical and surgical foot and ankle care for adults and children. Along with specialized training and the newest technology, we offer kindness and respect for every patient. We look forward to getting to know you, giving you the care you need, and getting you back up to speed.

Our knowledgeable, sensitive, and well-trained staff will be happy to assist you in every way.

Our mission is to provide the best possible comprehensive foot and ankle care in a comfortable, respectful, and professional environment.

To expedite your Check-In process please complete the enclosed paperwork to bring with you on the day of your appointment.

For your first visit, it is important that you also bring the following information with you:

1. A list of your medications both prescription and over-the-counter.
2. Your insurance card.
3. Your physician's name and phone number as well as any written referral information.

Payments for services not covered by your insurance plan or from any insurance co-payment, co-insurance, and/or deductible are expected at the time of service. If you have any questions or concerns regarding billing issues, please contact either your insurance carrier or our billing office at (704) 662-3660. For your convenience we accept cash, check, Visa/Mastercard.

For more information or directions to our offices, you can visit our website at www.footandankleassociates.com

We look forward to your visit.

143 Joe Knox Avenue
Suite 100
 Mooresville, NC 28117
704.662.3660 ph
704.662.3595 fx

16623 Birkdale Commons Pkwy
Suite 120
 Huntersville, NC 28078
704.892.5575 ph
704.892.6566 fx

3220 Prosperity Church Rd
Suite 101
 Charlotte, NC 28269
704.971.7100 ph
704.971.7101 fx

www.footandankleassociates.com

PATIENT INFORMATION

Patient Name

M S D W
Marital Status

Y N
Are you employed?

M F
Sex

Mailing Address

City

State

Zip

(_____) _____
Home Phone#

(_____) _____
Work Phone#

(_____) _____
Cell Phone#

Social Security#

E-mail address

Age

DOB

Employer Name

Occupation

Primary Care Physician

(_____) _____
Phone #

Parent/Guardian Name

Relationship to Patient

(_____) _____
Phone#

Emergency Contact

Relationship to Patient

(_____) _____
Phone#

Primary Insurance Co

ID#

Policy Holder Name

Employer

DOB

SSN#

Secondary Insurance Co

ID#

Policy Holder Name

Employer

DOB

SSN#

I wish to be contacted: (check all that apply)

- Email (Provided above)
- Home / Work / Cell Phone (circle all that apply)
- Mailing address (Provided above)

May we leave a detailed message? Y N

Authorization for treatment by Foot & Ankle Associates: I present myself or child for whom I am guardian for treatment, diagnoses and other services as deemed necessary or advisable by my doctor.

Medicare/Medicaid Patient's Certification: I certify the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request payment be made directly to the provider of services on my behalf and I authorize said provider to release any and all information necessary regarding the treatment and services provided as stated below.

Assignment of Benefits: I hereby authorize payment directly to Foot & Ankle Associates by my insurance carrier(s). In the event that payment is received from more than one insurance company creating an overpayment I understand that the overpayment will be sent to the appropriate payor. In the event overpayment is created due to my payment, I authorize the transfer of the overpayment to any unpaid bill of Foot & Ankle Associates for which I am responsible.

Payment of Services: I understand that I am financially responsible for all charges and fees related to the treatment and services rendered to me by Foot & Ankle Associates. I further understand that payment is expected at the time of each office visits to include co-payments, deductibles and any services not covered by my insurance.

Patient Signed Name (Guardian Name if a minor)

Date

Patient Printed Name (Guardian Name if a minor)

Relationship to patient



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HOW DID YOU HEAR ABOUT US?

Would you please take a moment and tell us how you heard about our practice. Please select as many of the following that apply to you. Thank you for helping us determine how our advertising is working for us!

NAME: _____ DATE OF TREATMENT: _____

Saw Advertisement in the Newspaper

- Charlotte Observer - Neighbors of Lake Norman
Charlotte Observer - Neighbors of University City
Huntersville Herald
Mooresville Tribune
Other: _____

Saw Advertisement in the Yellow Pages

- Bellsouth Yellow Pages - Lake Norman
Bellsouth Yellow Pages - Charlotte
Windstream Phone Book - Mooresville
Other: _____

Found Information on the Internet

- Insurance Provider Website
Yellow Pages Internet Listing
www.footandankleassociates.com
Other: _____

Direct Mail/Delivery

- Information received in the mail
Information delivered to my home
Other: _____

Other:

- Health Fair: Which one? _____
I was referred by a friend/family member. Who? _____
I was referred by a physician: Who? _____
I saw signage or banner: Where? _____
Other: (Please specify) _____

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