INDIAN VALLEY PODIATRY ASSOCIATES, P.C.

Philip J. Bresnahan, D.P.M., D.A.B.P.S., F.A.C.F.A.S.
Michelle Morrisey, D.P.M.
Lilya Kalyan, D.P.M.

601 E. Broad Street, Suite 220
Souderton, PA 18964
215-723-9688

484 Harleysville Pike
Harleysville, PA 19438
215-256-1060

PATIENT NAME _____ SOCIAL SEC#_____
(Last) (First) (M.I.) DATE OF BIRTH_____
ADDRESS_____ SEX M_____ F_____
CITY_____ STATE_____ ZIP_____
HOME PHONE# (_____)_____-_____CELL PHONE #(_____)_____-_____
WORK PHONE#(_____)_____- _____
E-MAIL ADDRESS_____

PERSON FINANCIALLY RESPONSIBLE FOR PATIENT: Please provide your insurance card (s):

INSURED'S NAME:_____
INSURED'S SOCIAL SECURITY #:_____INSURED'S DATE OF BIRTH_____
RELATIONSHIP TO PATIENT_____
ADDRESS (IF DIFFERENT FROM PATIENT'S)_____
HOME PHONE#_____WORK PHONE#_____
EMPLOYER_____ADDRESS_____

MEDICAL INFORMATION:

Height:_____ Weight:_____ Smoking Status: (check) ☐**Never** ☐**Quit** ☐**Current** **Shoe Size:_____**

Please describe your foot problem:_____
_____

Please list any and all prior surgeries:_____

Are you allergic to any medications? _____ If yes, please explain:_____

Do you have a history of or are you under care for any medical conditions? Please check those that apply:

DIABETES_____ KIDNEY AILMENT_____ FAINTING_____
HEART TROUBLE_____ RHEUMATIC FEVER_____ PHLEBITIS_____
SHORTNESS OF BREATH____ HIGH BLOOD PRESSURE_____ HEPATITIS_____
ASTHMA_____ POOR CIRCULATION_____ CIRRHOSIS_____
SEIZURE DISORDER_____ BLEEDING TENDENCY_____ OTHER_____

Please list any medications you currently take (include vitamins, supplements, aspirin & birth control pills:
_____

_____

Name of Family Physician:_____

PHARMACY:_____LOCATION_____

REFERRED BY:_____

PATIENT'S INSURANCE AUTHORIZATION

I hereby authorize the processing of the medical insurance either by electronic or manual method by the listed provider below. My signature authorizes payment of all major-medical and/or surgical benefits to which I am entitled from the listed insurer below to pay the listed provider assignee. I further authorize the assignee to release all medical and/or insurance claim information necessary to secure the payment (s). I recognize my financial obligation of any co-insurance or deductible, and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as an original.

Patient's Name (please print)

Patient's Signature

Today's Date

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Acknowledgment of Receipt of Notice

_____ _____
Name of Patient (please print) Patient's Date of Birth

_____ _____
Signature of patient or personal representative Today's Date

If signed by a personal representative, please complete information below:

_____ _____
Name of personal representative Relationship to patient

- -

Do you give us permission to leave information on your answering machine? If Yes, please fill in below.

_____
Telephone Number

- -

Do you give us permission to leave a message on your voice mail? If yes, please fill in below.

_____
Voice mail #

- -

Do you give us permission to release your medical information to a spouse, child, sibling, or personal representative? If yes, please fill in below.

Name Relationship to patient

_____

_____

Signature of Patient

_____ Today's Date_____

NOTE: IT IS THE PATIENT' RESPONSIBILITY TO KEEP THIS INFORMATION CURRENT.

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When seeking medical treatment, patients for their own well being, not only need to understand their medical condition, but also their financial responsibility. We are here to aid in your financial claim processing, but ultimately the patient's responsibility for outstanding balances are due to the medical care they receive.

We thank you in advance for taking the time to review these policies and appreciate your compliance and cooperation.

Please feel free to discuss any concerns or questions you may have with our billing staff.

Things to bring with you to your vist:

- Health Insurance Card (will be checked at every visit)
- Driver's License
- Method of payment – for your convenience we accept cash, check, debit, and credit cards. The credit cards we accept are Visa and Mastercard.

Patient out of pocket expenses:

- We are obligated to collect the co-pay at the time of your visit. This is a requirement of your insurance plan. Remember to stop at the front desk each visit to pay your co-pay.
- All payments are due at the time of service.
- For self pay, deductible, or other large amounts, we offer credit cards and monthly payments plans for your convenience. Monthly payment plan must be arranged with the Office Manager.

Full Pay

- We offer a reasonable discount for cash pay/fee for service patients who have NO health insurance coverage.
- Payment in full is expected at the time of visit unless prior arrangements have been made with the Office Manager.
- We understand that you may be applying for Medical Assistance to help defray these costs. We will expect monthly payments on your account until you can prove you have been enrolled for coverage with MA. Any monies collected for services rendered after your eligibility date will be refunded. You are responsible for informing us when you become active with MA.

HMO Plans:

- You must obtain a valid referral prior to being seen. This is a requirement of your insurance plan.
- If you do not have a referral at the time of your visit, you will be asked to sign a waiver stating you are aware that you are responsible for payment upon check out on that day or you will need to reschedule your appointment.

Litigation cases:

- We do not get involved with any litigation accounts, disputed work comp cases, divorce decrees or auto accidents. You will be 100% responsible for any balances due.

Returned checks:

- There is a $25.00 fee for all returned checks, in addition to any bank charges.
- Payments after a returned check are cash or credit card only.

Oustanding balances/Collections:

- Prior to providing additional services to you, payment in full of total outstanding balances will be required.
- Patient's with two or more delinquent accounts, or delinquent accounts greater than $500.00, may be discharged from the practice.
- Billing statements will be mailed for balances that are denied or deemed patient responsibility. Payment is expected within three weeks of the billing date. If no payment has been received a second statement will be sent. In the event a third statement is required, additional collection steps will be taken. Your failure to make payment may result in your account being turned over to a third party collection agency who reports to the credit bureau.

I have read and understand Indian Valley Podiatry Associates, P.C. financial policy.

Printed Name Patient Name if Minor

Date

Relationship to patient: _____Self _____Parent _____Other