PATIENT REGISTRATION

Patient Information

Patient Name: Last	First	M.I.	Gender: M F

By what name do you prefer to be addressed?	Marital Status:

Patient's Address:

City:	State:	Zip:

Home Phone:	Cell Phone:	E-mail Address:

Social Security #:	Birth date:	Age:

Employer:	Phone:	Occupation:

Emergency Contact:	Phone:

Insurance

Insurance Name:	Policy ID:
Name of insured (if other than self):	Birth Date:
Name of insured's employer:	Insured's work phone number:

Patient relation to subscriber:

Name of person responsible for paying the bill (the Guarantor):

Guarantor's Address:	Guarantor's Phone:

L & I Injury

Date Of Injury:	Type of Injury: ☐ Work ☐ Auto ☐ Other

Has a claim been filed? ☐ Yes ☐ No	Claim #:	Where was claim filed?

Cause of injury:

Referral

Referred By: ☐ Web search (Google, Yahoo) ☐ Online yellow pgs ☐ Insurance Web Site or Book
☐ Phone Book yellow pgs ☐ Dr. : __________________
☐ Patient of office/Relative: ________________________Thank you address:______________________________________
OR are you a ☐ Previous patient of this office
Primary Doctor: ______________________Seen last: ___________________________________
Pharmacy Used: ___________________________________Location: ____

Signature

Release of Benefits Information

I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctors' office will bill my insurance as a courtesy and that I am responsible at the time of service for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. (If not signed payment due at time of service)

ALL CO-PAYMENTS DUE ON DAY SERVICE.

DO WE HAVE PERMISSION TO: LEAVE A MESSAGE ON YOUR ANSWERING MACHINE ☐ YES ☐ NO
LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT ☐ YES ☐ NO DISCUSS YOUR MEDICAL CONDITION WITH ANY MEMBER OF YOUR HOUSEHOLD ☐ YES ☐ NO IIF YES, WITH WHOM? ____
RELATIONSHIP ____

Patient Signature:____ Date:____________________________________

Parent of Authorized Representative (If applicable) ____

MEDICAL HISTORY

Patient name:_________________________________ Date of Birth: ___________ Today's Date: ________

Foot complaint: ______________________________ ☐ **right** ☐ **left** ☐ **both**

Have YOU ever had any of the following: (circle all that apply) ☐ None

High blood pressure	Diabetes	Thyroid problems
Heart attack	Peripheral neuropathy	Gout
Coronary bypass/stent	Peripheral vascular disease	Depression
Congestive heart failure	Foot ulcers/wounds	Anxiety disorder
Heart murmur	Arthritis (back, knees, hips, feet or other)	Leg swelling/edema
Pacemaker	Joint replacement	Varicose veins
Blood clotting disorder	Stroke	Heart surgery
DVT (deep venous thrombosis)	Paralysis	Orthopedic surgery
MRSA infection	Asthma	Previous chemotherapy
Chronic pain syndrome	COPD	Cancer surgery
Liver disease	Alcoholism	
Kidney disease	Cancer	
Dialysis	Fibromyalgia	

Other medical problems or surgeries please list here

____

____

Allergies: (circle all that apply) Adhesives/tape Latex Penicillin Iodine Sulfa Aspirin
Ibuprofen Anesthetic Agents

Other: ____ ☐ I have no known drug allergies

MEDICATIONS: please list here or ☐ I have brought a list to photocopy ☐ I take no medications

____

____

____

____

SOCIAL HISTORY: ☐ Single ☐ Married ☐ Widowed

☐ Employed ☐ Full-time ☐ Part-time ☐ Retired ☐ Don't work outside the home

☐ Current Smoker ☐ Former Smoker ☐ Non-Smoker

Approximate -- height _____________ weight _________________ Shoe Size _______________

NOTICE OF PRIVACY PRACTICES

We understand that health information about you and *your* health is personal. We are committed to protection your health information. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will inform you about the ways we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this notice of your legal duties and privacy practices with respect to health information about you. Follow the terms of the Notice of Privacy Practices that is currently in effect.

How we may use and disclose health information about you:

- For treatment For payment
- For appointment reminders As required by law
- Public health risks
- Health oversight activities Lawsuits and disputes Law enforcement
- Coroners, heath examiners and funeral directors. To avert a serious threat to health and safety
- As required by the Military of Veterans Administration National security
- Worker's Compensation

Your rights regarding health information about you:

- Rights to inspect and copy. We may charge you .88 for each page, up to 30 pages .67 there after, and a $20 clerical fee for staff time to locate and copy your protected health information. Postage will be charged if you want the copies mailed to you. X-rays copies will be billed at $12 per film sheet. We ask a 2 day notice to be given. Legally, we are given 30days within which to provide you with your copies.
- Right to amend
- Right to request confidential communications
- Right to a paper copy of this notice (full notice is available upon request)

Changes to Notice of Privacy Practices:

We reserve the right to change this notice. We will post a copy of the current notice in our facility with the current effective date on the first page.

Complaints:

If you believe that your privacy rights have been violated you may file a complaint with us. All complaints must be in writing. Please contact HIPAA Officer to file a complaint.

Acknowledgement of Receipt of this Notice:

This acknowledgment will become part of your records.

Please print name: ____

Signature: ____ Date: _____________________

Parent of Authorized Representative (If applicable) ____

FINANCIAL POLICY

Thank you for choosing Family Foot Center to be your podiatric physicians. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. As part of our service, we try to contain the cost of healthcare. In an effort to do this, we have implemented a Financial Policy.

The following is a statement of our **FINANCIAL POLICY** which we request you read and sign prior to any treatment. To avoid any misunderstandings, please contact us should you have any questions about our policies.

INSURANCE: Please do not expect us to know the terms, conditions and individual coverage limits of your insurance policy. If you have questions regarding benefits and eligibility please contact your insurance carrier to determine what your benefits are. This includes verifications as to whether one of our doctors is a contracted provider with your insurance carrier. Please note that you are ultimately responsible for payment for all services that are not covered by your insurance plan.

NO INSURANCE: If you do not have insurance or the doctor is not participating with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment. Payment arrangements will be made prior to your visit with the physician.

PAYMENT: Payments for the balance due, co-payments, deductibles, etc. are due at the time of service and may be made by *cash, check, or credit card. (VISA or MASTERCARD)*. There will be a $25.00 charge for all returned checks. Delinquent accounts will be referred for collection at the discretion of the office manager.

CO-PAYMENTS & DEDUCTABLES: We require that all deductibles, co-payments, and other non-covered services be paid by you at the time of your visit. We will add a billing fee of $5.00 if you do not pay your co-payment at the time of service.

INTEREST: Please be advised that any account balance owing past 30 days will be assessed with a 1.5% interest per month (or 18% annually).

MISSED APPOINTMENTS: Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. We reserve the right to charge for missed appointments.

ORTHOTICS: Orthotics are a non-covered service by some insurance plans. Please check with your insurance company prior to the examination and casting for orthotics to determine your orthotic benefits. A deposit of $200.00 is requested at the time of the examination and casting and full payment is due when the orthotics are dispensed. Orthotics are non-refundable nor non-returnable.

SUPPLIES: For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at time of purchase. We cannot bill for these items.

I have read and agree to the terms set forth in the above financial policy. I am financially responsible for any balance due.

Printed patient name: _________________________

Signed ____ Date __________________________

Parent of Authorized Representative (If applicable) ____