TAMARA S. MARTIN DPM

PATIENT INFORMATION RECORD
NOTICE OF PRIVACY PRACTICES/PATIENT CONSENTS

Name: ______________________ Social Security No.: ______________________
Address: ____
City: ______________________ State: ____________ Zip Code: ____________
Telephone Number: ______________________ Cell Number: ______________________
Age: ______ Date of Birth: ______________________
Family Physician: ______________________ Email Address: ______________________

Employer: ______________________ Occupation: ______________________
Address of Employer: ______________________ Employer's Phone: ______________

Marital Status: ________ Name of Spouse: ______________________
Address: ______________________ Cell Phone: ______________________
Employer: ______________________ Occupation: ______________________
Employer's Phone: ______________________ Date of Birth: ______________________

How did you hear about our practice? Web Yellow Pages Dr. Referral Friend/Family
please circle one

Check Each Box as to how you agree to the disclosure of your personal health information.

YES	NO	
☐	☐	I was offered a copy of the "Notice of Privacy Practice" for Tamara S. Martin, D.P.M.
☐	☐	You have my permission to leave messages on my answering machine and to mail written notices to my home address regarding appointment, negative test results, etc.
☐	☐	You have my permission to forward any requested records to my family Practice doctor.
☐	☐	You have my permission to forward any requested records to a referring doctor or facility.
☐	☐	You have my permission to give the following family members/friends access to my personal health information.
☐	☐	The same family members/friends may pick up prescriptions/samples from the office for me.

Family Members and Friends List:

____

***PLEASE NOTE: THERE WILL BE A $25.00 CHARGE FOR ANY RETURNED CHECKS!**

INSURANCE INFORMATION

Name of Insurance Company: ____
Policy No. ID#: ______________________ Group #: ______________________
OTHER INSURANCE COMPANY: ______________________ ID#: ______________________

I hereby give my permission to Dr. Tamara S. Martin to administer treatment and perform such minor procedures as may be necessary in the diagnosis and or treatment of my foot or leg condition.

Signed: ____ Date: ______________________

AUTHORIZATION/RESPONSIBILITY AGREEMENT
PATIENT ACKNOWLEDGEMENT OF
NON-COVERED SERVICES AND REFERRAL RESPONSIBILITY

If you have insurance coverage, please understand that this is an agreement between you and your insurance company. You are responsible for the payment of your bill regardless of the status of your insurance claim.

I hereby authorize Dr. Tamara Martin to release to my insurance company, or their representative, any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care.

I hearby authorize my insurance company to pay the proceeds of any benefits due directly to:

DR. TAMARA S. MARTIN
7011 SHALLOWFORD ROAD STE. 103
CHATTANOOGA TN 37421

I understand that responsibility for payment for any medical or surgical services provided by Dr. Martin, for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I understand that insurance is filed as a courtesy, but the balance is still my responsibility, regardless of any insurance coverage that I may have. (ANYACCOUNT BALANCE MUST BE PAID IN FULL WITHIN 60 DAYS TO PREVENT FURTHER ACTION; A REPEAT BILLING FEE OF $3.00 WILL BE ADDED TO ANY ACCOUNT OVER 60 DAYS OLD)

In the event that this account is placed in the hands of an attorney or other agency for collection, but suit or otherwise, I/we agree to pay all cost of collection, including a reasonable attorney or agency fee and all court costs associated with this matter.

**Any procedure, services, or medical devices (including Medicare DME) that are considered non-covered by your insurance plan is your responsibility.
**I understand that it is my responsibility for any charges associated with my healthcare that may not be covered by my insurance carrier.
**I understand that it is my responsibility to obtain any referrals that may be needed for continued services for this office. If a referral is not obtained then the charges are my responsibility.

I have read and understand the policies stated above.

______________________________ ____________________
Patient or Guarantor Signature Date

TAMARA S. MARTIN, DPM
7011 SHALLOWFORD ROAD STE. 103
CHATTANOOGA, TN 37421