PATIENT INFORMTAION

NAME ____

ADDRESS ____

____

PRIMARY PHONE ______________________ **WORK PHONE** ______________________

EMAIL ____

DATE OF BIRTH _____/______/______ **MALE/FEMALE**

MARITAL STATUS MARRIED SINGLE DIVORCED WIDOWED

SOCIAL SECURITY ______-______-______ **EMPLOYER** ______________________

PRIMARY DOCTOR ______________________ **REFERRED YOU HERE?** Y/N

INSURANCE CARRIER'S NAME ______________________ **DOB** ____________

RESPONSIBLE PARTY'S NAME ______________________ **PHONE** ____________

EMERGENCY CONTACT PHONE NUMBER ______________________

EMERGENCY CONTACT NAME ______________________

AUTHORIZATION TO RELEASE INFO

I authorize the release of my medical/personal information to process my insurance claim.

SIGNATURE____ **DATE**______________

AUTHORIZATION TO PAY BENEFITS TO THE DOCTOR

I authorize and request payment to be made directly to First Podiatry/Jane Koch/David Reynolds for any healthcare benefits due under the terms and conditions of my insurance policy for services rendered or devices purchased.

SIGNATURE____ **DATE**______________

ACKNOWLEDGE OF GOVERNMENT PRIVACY ACT

I understand the Government's Privacy Act (HIPAA) and understand that I may obtain a copy of this information if needed.

SIGNATURE____ **DATE**______________

FIRST PODIATRY FINANCIAL POLICY

I understand that if any unpaid balance is assigned to a third party collection agency or placed with an attorney to obtain judgement or otherwise satisfy payment on my account, a collection fee of 33 1/3% of the unpaid balance will be added to my account. I agree to pay that fee. I further agree to pay reasonable attorney fees and court costs if a judgement is granted against me. I authorize First Podiatry, PC and HSC Medical Billing and Consulting, LLC to contact me by telephone at any of the numbers provided on my patient information sheet, including my wireless phone of me and/or my spouse, which could result in charges for me/us. I acknowledge that my spouse or I may be contacted by sending text messages, and/or emails, using any email address I have provided. Furthermore, I also authorize methods of contact that my include using pre-recorded and/or artificial voice messages and/or automatic dialing services, if applicable.

I agree to be financially responsible for any/all deductibles, coinsurance, copays, and/or procedures that are non-covered or excluded from my insurance plan.

I agree to pay $30 if I have a check returned for insufficient funds or account closure.

I agree that it is my responsibility to know what procedures are covered under my insurance plan. I am also responsible for knowing if the procedure or product needs prior authorization.

I agree that if I am prescribed CUSTOM MADE ORTHOTICS, that I am responsible for the payment of these orthotics, regardless if I pick them up or not. These are custom made devices and cannot be returned.

SIGNATURE____ **DATE**______________