



BAYSHORE PODIATRY CENTER

PATIENT INFORMATION FORM

Date: _____ Age: _____

Patient's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Patient Social Security #: _____ Sex: M _____ F _____

In case of Emergency Contact: _____

Whom may we thank for referring you? _____

Primary Care Physician: _____ Phone Number: _____

Address: _____ City/State: _____

Insurance Information: (This must be filled out before we can bill your insurance company.)

Employer's Name: _____ Work Phone #: _____

Insured Name: _____ Insured Date of Birth: _____

Insured Social Security #: _____ Occupation: _____

Name of Insurance: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

ID#: _____ Group #: _____

Secondary Insurance Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Address: _____ Phone #: _____

*Please present this form, your driver license and all insurance I.D. cards to the receptionist at this time. *

Date:

Signature:

BAYSHORE PODIATRY CENTER

HEALTH INFORMATION / PLEASE CIRCLE YES OR NO

WHAT IS YOUR CHIEF COMPLAINT? _____

HOW WOULD YOU RATE YOUR GENERAL HEALTH? _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

DO YOU HAVE DIABETES? YES NO

IS THERE A FAMILY HISTORY OF DIABETES? YES NO

ARE YOU TAKING BLOOD THINNERS? YES NO

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO

(IF SO, PLEASE LIST) _____

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING LISTED BELOW?

- DIABETES YES NO
- ASTHMA YES NO
- EPILEPSY YES NO
- RHEUMATIC FEVER YES NO
- KIDNEY DISEASE YES NO
- LIVER DISEASE YES NO
- NERVOUS DISORDER YES NO
- TUBERCULOSIS YES NO
- CANCER YES NO
- HIGH/LOW BLOOD PRESSURE YES NO
- HARDENING OF ARTERIES YES NO
- STDS..... YES NO
- PHLEBITIS YES NO

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? _____

DO YOU SUFFER FROM ANY OF THE FOLLOWING LISTED BELOW?

- 1. SWELLING OF THE FEET, ANKLES, OR LEGS?..... YES NO
- 2. LEG CRAMPS WHEN WALKING OR AT NIGHT?..... YES NO
- 3. ENLARGED VEINS?..... YES NO
- 4. LOWER BACK PAINS?..... YES NO
- 5. TINGLING, BURNING, OR LOST OF SENSATION IN FEET?..... YES NO

Date:

Signature:

RELEASE AND ASSIGNMENT OF BENEFITS

I, the undersigned, authorize payment of the medical and surgical benefits directly to Bayshore Podiatry Center; and to release information including the diagnosis and the records of any such medical or surgical care. I am also giving Bayshore Podiatry Center all rights to inquire on my behalf on any medical reviews relating to my medical benefits, whether assigned or non- assigned claims.

I acknowledge that I may receive durable medical equipment, and various other types of medical supplies. I understand that these items can not be returned to the office; however, they may be adjusted or corrected as deemed medically necessary. I also understand that the use of these items is not a guarantee for treatment or healing.

In our attempt to better serve the needs of our patients, we have been forced to initiate our current policy of a \$40.00 charge for broken appointments without proper notice. We understand that 24 hour notice is not always possible, but please call us as soon as you realize that you will not make the appointment. Thank you for your cooperation and understanding.

Patient Signature and Date

FINANCIAL AGREEMENT

Dear Patient:

We are committed to providing you with the best possible podiatric care. To help us achieve this goal, we need your assistance and understanding of our payment policy.

The amount of benefits you are entitled to will depend solely on what your specific insurance company offers to its members. Your co-pay is required at the time of your visit. Some insurance plans cover as little as 30% and some as much as 100% of your medical care, with most falling in the 50-80% range. **Almost all plans (including PPO's, Medicare, and Medicaid) exclude certain services that you may not be aware of. Our staff recognizes this and will attempt to take the time to discuss charges with you prior to a service if we know your insurance will not cover it.**

Some plans base the amount of benefits on a chart or schedule of fees arbitrarily developed by the insurance carrier. The actual amount paid by your plan is 80% of the fee made up by the insurance company, not the actual fee charged by our office. Our fees are generally considered to fall within the acceptable range of most carriers and therefore most procedures are covered up to the maximum allowance determined by each carrier. This applies only to those companies who pay a percentage (30, 50, or 80%) of the U.C.R.; which is defined as usual, customary and reasonable fees for this region.

We greatly appreciate the opportunity to provide your podiatric care and feel it is only fair in our provider-patient relationship that you be fully aware of the policies of this practice, as well as the type of service and care that we provide.

The type of treatment you receive is **NOT** based on the type of insurance plan you have. It is not in the best interest of the patient to compromise quality care in order to satisfy an insurance company's fee schedule.

If you are a member of an insurance company that we are affiliated with, we will file the claim directly with the insurance company, minus the portion you, the insured, are responsible for. We will then bill you if there is a balance remaining after the carrier has paid, or will reimburse you if the carrier pays more than expected.

- If you are a member of a plan that we are not affiliated with, we ask that you pay the full amount of your visit, at the time of your visit. Our office staff will be happy to provide you a copy of your master bill, which has the nationally accepted diagnosis and treatment codes necessary for your insurance company to process your claim. We gladly accept the following payment methods: Cash, Check, MasterCard, Visa, and Discover. **Returned checks are subject to a \$25.00 processing fee**
- If your benefit plan required a pre-certification or pre-authorization, we will submit a treatment plan for review by your carrier. Please be aware that, per your insurance carrier, pre-authorization does not guarantee payment.

- Your insurance company is expected to either pay or deny the claim within 60 days. We will do everything we can to expedite your claim. Should the insurance company delay payment, you will ultimately become responsible for the payment of the medical services you received and in turn your insurance carrier will be responsible to you.
- We realize that temporary financial problems may affect your ability to pay your medical bill in full. If such problems arise, please contact our office at once and we will work out a payment plan agreeable to both of us. If the patient does not make payments as agreed and collection efforts are necessary, a \$20.00 processing fee and a 1.5% interest charge per month will be added to the unpaid balance.
- **If your insurance required physician referrals, it is your responsibility to obtain them. If you do not have a valid referral at the time of your office visit, you will be responsible for all charges incurred. Do not depend on your office staff to keep track of your referrals for you.**

Of you have any questions about this agreement or are uncertain regarding your insurance coverage, we will answer your questions as best we can; we are here to help you. Your insurance company may also be helpful in answering more specific questions regarding your plan.

Sincerely,

The Doctors and Staff

Patient Signature and Date

Notification of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payments from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that your **Notice of Privacy Practices** contains a more complete description of the uses and disclosures of my health information and a copy is available to me upon my request. I understand that Bayshore Podiatry Center has the right to change its **Notice of Privacy Practices** from time to time and that I may contact Bayshore Podiatry Center to obtain a current copy of the **Notice of Privacy Practices** at any time.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions.

The following is a listing of the person or persons (usually a spouse) whom I authorize to have access to my medical and billing records at this facility.

Name: _____

Relationship: _____

Signature: _____

Date: _____