PATIENT REGISTRATION

DEMOGRAPHIC & CONTACT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ (mm/dd/yyyy) SEX: _____ SOCIAL SECURITY #: _____

ADDRESS : _____ CITY: _____ STATE: ____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ EXT: _____

CELL PHONE: _____ EMAIL: _____

I agree and consent to S F Foot Specialist PLLC communicating with me in the following ways (please check):

VIA POSTAL MAIL TO MY HOME ADDRESS ☐ YES ☐ NO

VIA HOME TELEPHONE: ☐ OK TO LEAVE DETAILED MESSAGE? ☐ LEAVE CALL BACK # ONLY

VIA CELL PHONE : ☐ OK TO LEAVE DETAILED MESSAGE? ☐ LEAVE CALL BACK # ONLY

OK TO SEND TEXT MESSAGES FOR APPOINTMENT REMINDERS? ☐ YES ☐ NO

OK TO SEND TEXT MESSAGES TO COMMUNICATE WITH OFFICE STAFF/DR? ☐ YES ☐ NO

VIA EMAIL: ☐ OK TO SEND APPOINTMENT REMINDERS? ☐ OK TO SEND BILLING INFO?

VIA EMAIL: ☐ OK TO COMMUNICATE WITH OFFICE STAFF/DOCTOR?

Authorization to release or use information for treatment, payment, or health care operations

- I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by S F Foot Specialist PLLC to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.
- We reserve the right to change the terms of our Notice of Privacy Practices at any time. If we do make changes to the terms of our Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.
- You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or heath care operations by simply writing our office with the request.

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: _____ CONTACT LAST NAME: _____

CONTACT HOME PHONE: _____ CONTACT CELL PHONE: _____

RELATIONSHIP TO PATIENT: _____ CONTACT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PRIMARY CARE PHYSICIAN'S NAME: _____ PRACTICE: _____

CITY: _____ STATE: _____ ZIP: _____ LAST DATE SEEN: _____

PHARMACY NAME: _____ PHARMACY PHONE: _____

PHARMACY LOCATION: _____ HOW DID YOU FIND US? _____

By signing below, I attest that the information provided above is true and accurate and I agree and understand any policies or authorizations listed above:

Signature of Patient /Guardian: _____ **Date:** _____

INSURANCE INFORMATION &
FINANCIAL RESPONSIBILITY POLICY ACKNOWLEDGEMENT

PRIMARY INSURANCE: COMPANY NAME: _____ CO-PAY: _____
GROUP #: _____ SUBSCRIBER #: _____ RELATION TO PATIENT: _____
INSURED FIRST & LAST NAME: _____ DOB: _____
CLAIM ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
PHONE #: _____ PAYER ID#/EDI #: _____

ADDITIONAL INSURANCE: ARE YOU COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO
COMPANY NAME: _____ GROUP #: _____ SUBSCRIBER #: _____
INSURED NAME: _____ DOB: _____ RELATION TO PATIENT: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

- **Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card.**
- **Most private insurance policies (non Medicare/Medicaid) plans now have deductibles, copayments, coinsurances, maximums and limitations (out of pocket expenses). If your annual out of pocket expenses have not been met, you may be asked to pay a $125 pre-payment toward your balance at the time of your visit.**
- **We rely on you to inform us of all insurances in effect and to notify the office immediately of any changes with your insurance. If you do not inform us of changes, you will be responsible for the services rendered. When multiple policies exist, it is the patient's responsibility to inform us which policy is the primary plan. If we are not provided ALL insurance information at the time of service, you may be responsible for paying our clinic directly and then submitting for reimbursement from your insurance company.**
- **All charges are the responsibility of the patient. We will bill your insurance company, but any services not covered are the patient's responsibility. If you have no insurance, you are responsible for all services rendered. Co-pays will be collected at the time of the appointment (as required by insurance companies). For new patients, we will make every attempt to contact your insurance company to determine your office visit copayment, if any. Existing patients should notify us of any changes related to copayment amount right away.**
- **Costs can vary, depending on the type of insurance coverage you have and the treatment for your particular condition(s.) Cost/payment by your insurance company cannot be guaranteed by our staff. If you have any concerns, we advise you to contact your insurance company directly.**
- **If you repeatedly miss an appointment or cancel an appointment less than 24 hours of the appointment time, you may be assessed a $25-75 fee (depending on the type of appointment missed), as we have reserved that time slot just for you. Missed appointment fees are the responsibility of the patient.**
- **A $50 fee will be assessed on all returned checks.**
- **Past due accounts, where 3 or more statements have been sent, may be turned over to our collection agency and a $25 administrative fee may be charged.**
- **We reserve the right to charge a fee of $25 for completion of disability forms and or other packets of requested documentation that require a significant amount of the doctor's time to complete.**

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT

By signing below, I attest that the information provided above is true and accurate, and that I have read and understand the Financial Policy for S F Foot Specialist PLLC.

Signature of Insured / Guardian: _____ **Date:** _____