Dr. Gabriel Rodriguez, DPM
3900 W 41st St
Sioux Falls, SD 57106
605-274-2564 (phone)
605-274-2562 (fax)

Sioux Falls Foot Specialist
Foot pain? We can help.

Patient Name_____ Date of Birth _____

SSN_____ Insurance Provider_____

Patient Address_____
(Street) (City) (State) (Zip)

Mobile Phone (_____)_____-_____ Work Phone (_____)_____-_____

Home Phone (_____)_____-_____ Email Address_____

Would you like to receive appointment reminders via text and/or email? ❑ Yes ❑ No

Preferred Pharmacy:

_____
(Name) (City/State/Zip) (Phone)

Name of Primary Care Doctor _____

Primary Doc's Phone (_____)_____-_____ Last Visit Date _____

Emergency Contact Name _____

Phone Number_____ Relationship to you _____

How did you hear about Sioux Falls Foot Specialist? (please mark one below)

Other Doctor (list name)_____ Friend/Family (list name)_____

Your Insurance Company_____ Social Media (list which)_____

Internet/Google Search_____ Other _____

_____ _____ _____

Patient Name (Print) Patient Signature Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND OTHER IMPORTANT NOTICES TO OUR PATIENTS

Please read this page carefully as it pertains to your personal information.

ABOUT YOUR PRIVACY:

This office has our policy on what we do with your personal information (HIPAA notice) posted at the reception area. You have the right to review our privacy practices at any time. If you would like to request a copy of our HIPAA Privacy Policy, please ask Reception and a copy will be provided to you.

☐ I have read and understand the HIPAA notice.

☐ I decline reading the HIPAA notice but, I am fully aware that it is available to me.

AUTHORIZATION TO RELEASE YOUR MEDICAL INFORMATION:

I give permission to SF Foot Specialist, PLLC to release my information, either verbal, written, or digitally regarding my medical condition and treatment for the purpose of medical management and also to the following people:

_____

_____

_____

(Please note: You may cancel this request at any time by advising this office in writing to do so.)

ADDITIONAL NOTICE TO OUR PATIENTS:

As of 04/01/2021, SF Foot Specialist will be adding a NO SHOW FEE when 24 hour advanced notice (or greater) is not given to us for your scheduled appointments.

_____

Patient name (print)

_____

Signature of Patient/ Legal Guardian Date:

Sioux Falls Foot Specialist

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Financial Policy

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. The patient or guaranteeing party is responsible for their bill being paid in full. Please inform us at every visit of any changes to your insurance coverage.

Please initial each line indicating your understanding of our policies:

___**COPAYMENTS:** It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor.

___**DEDUCTIBLES & CO-INSURANCE:** If you have a high deductible plan, we may collect a **$125** deposit to apply towards your deductible and co-insurance. Any remaining balance after submission to your insurance company is your responsibility.

___**SELF-PAY:** Full payment is due at time of service. A down-payment will be required before seeing the doctor. **At a minimum, an evaluation and management fee of $150.00 will be charged.** Additional procedures/services may be recommended by the doctor. You will be informed of these charges before proceeding with treatment.

___**REFERRAL:** If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we may need to reschedule your appointment.

___**NO SHOW: 24 hours' notice** is required for cancellation of your appointment and failure to do so will incur a **$50 fee** charged directly to you. Failure to provide **24 hours' notice** of an office procedural visit will incur a **$75** fee.

___**SURGERY CANCELLATION:** Failure to provide **5 business days'** notice before surgery will incur a **$500** fee. Plus, a possible fee from the Surgical Center billed out by them.

___**BALANCES/COLLECTION FEES:** If balance is not collected within 30 days from the postmark date of a 3rd mailed statement, a **$12** re-billing fee may be added to each additional statement due to an unpaid balance. Accounts due more than 180 days will be subject to being turned over to our collection agency and a **$35** administrative fee will be added.

___**FMLA/DISABILITY/MEDICAL RECORDS:** There is a **$50** charge for having the doctor complete these forms. There is a **$15** fee to obtain a copy of your medical records.

I have read and understand these financial policies.

Patient Name (print):_____

Patient/Responsible Party Signature:_____
Date:_____