PATIENT INFORMATION

NAME_____

ADDRESS_____

_____

PRIMARY PHONE_____OTHER PHONE_____

DATE OF BIRTH_____/_____/_____ SSN:_____ Gender: _____

MARITAL STATUS: MARRIED SINGLE WIDOWED DIVORCED

EMPLOYER_____TITLE_____

PRIMARY DOCTOR_____

REFERRED BY? _____

INSURANCE POLICY HOLDER'S

NAME _____DOB_____

RESPONSIBLE PARTY'S NAME_____DOB_____

(IF PATIENT IS CHILD OR HAS POA OR GUARDIAN)

EMERGENCY
CONTACT_____PHONE_____

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 DOCTOR

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

SIGNATURE_____DATE_____

ACKNOWLEDGEMENT OF GOVERNMENT PRIVACY ACT

I understand the Government's Privacy Act (HIPAA) that become effective in 1996 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. Furthermore, I authorize methods of contact that may include using pre-recorded and or artificial voice messages and or automatic dialing devices, is applicable.

I agree to be financially responsible for any and 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 a procedure or product needs prior authorization or pre certification.

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 and cannot be returned.

SIGNATURE_____DATE_____