

PATIENT INFORMATION FORM

TODAY'S DATE _____

Welcome to our office. Please print clearly and complete both sides of this form.

REFERRED BY _____

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PATIENT INFORMATION

NAME _____ (LAST) _____ (FIRST) _____ (MIDDLE) _____ (NICKNAME)

BIRTHDATE _____ (MONTH - DAY - YEAR) SOCIAL SECURITY # _____ MARITAL STATUS _____

ADDRESS _____ (STREET) _____ (CITY) _____ (STATE) ZIP CODE _____

HOME PHONE () _____ WORK PHONE () _____ CELL PHONE () _____
 (AREA CODE) (AREA CODE) (AREA CODE)

EMPLOYER _____ ADDRESS _____

SPOUSE (OR PARENT) INFORMATION

NAME _____ PHONE NUMBER _____

EMPLOYER _____ SOCIAL SECURITY # _____

EMERGENCY CONTACT INFORMATION (OUTSIDE OF HOUSEHOLD)

NAME _____ (LAST) _____ (FIRST) _____ (MIDDLE)

ADDRESS _____ ZIP CODE _____

PHONE NUMBER () _____ RELATIONSHIP TO PATIENT _____

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In order to submit insurance claims to your insurance companies/programs, we request a current copy of all your insurance cards. As the patient, it is your responsibility to determine whether the doctor participates in your plan, and your plan benefits and coverage. You must also obtain prior authorization and/or physician referrals if required by your insurance carrier. Please inform our office when your insurance coverage changes.

Please list all insurance companies or programs that you are eligible to receive benefits including such programs as Medicare, Medicaid, TRICARE/CHAMPUS, and listing Insurer's name, address and date of birth.

Primary _____ Insured's name/address/birthdate _____

Secondary _____ Insured's name/address/birthdate _____

Tertiary _____ Insured's name/address/birthdate _____

I certify I am eligible to receive benefits from the above listed insurance companies/programs, and that I have listed all of my insurance coverage.

PATIENT OR PERSON AUTHORIZED TO CONSENT FOR PATIENT/RELATIONSHIP/ADDRESS _____

REASON PATIENT WAS UNABLE TO CONSENT _____ DATE _____

If you (the patient) **do not have insurance** coverage, please complete:

I certify I (the patient) am not eligible to receive benefits from any insurance companies/programs, and will pay in full at the time of service.

PATIENT OR PERSON AUTHORIZED TO CONSENT FOR PATIENT/RELATIONSHIP/ADDRESS _____

REASON PATIENT WAS UNABLE TO CONSENT _____ DATE _____

If you (the patient) are seeing the doctor because of an **accident**, please complete:

Date of accident/injury _____ Type of accident/injury _____

Is this a worker's compensation claim? Yes No

If yes, please provide the name, address, and telephone number of the worker's compensation insurance company:

Payment is expected at the time of service, including co-payments, and deductibles, etc. For your convenience, payments can be made by check, cash, Visa, MasterCard or Discover.

I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits. I agree to pay for the services rendered to me at the rates now in effect or to become effective during the course of my visits. If there is an overpayment by me, or on my behalf, I direct Capital Foot Center, P.C. to apply the overpayment to any other unpaid account I may have with Capital Foot Center, P.C. I acknowledge that all billings for services are due and payable at the time of service or within 30 days of the date thereof. I understand that I may be charged and agree to pay interest, which will accrue monthly at the rate of 1% per month beginning 30 days after the date of service; and that in the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances if allowed by state and federal law. I understand that a service charge of \$30.00 will be assessed my account for each insufficient funds check received and agree to pay this service charge.

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REASON PATIENT WAS UNABLE TO CONSENT

DATE

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Capital Foot Center, P.C., its employees and John Tenny, D.P.M., Teresa Burnap, D.P.M., and Torrey Rassfeld, D.P.M. to release any and all information from my medical record including information concerning medical and hospital records, and not exclusive of information regarding psychiatric or mental health treatment, tobacco, alcohol or drug abuse, cancer, AIDS/HIV related information, and other communicable disease related information for the completion and processing of all claims for services and treatments. I understand that my medical record contains information which includes, but is not limited to, any medical condition I have had in the past, now have, or may have in the future, presenting symptoms and complaints, any histories, findings on examination, medical treatment, hospitalization, bills, financial information, operative reports, lab test results, x-rays and reports, diagnostic tests and reports, consultative reports, daily progress reports or notes, and medications.

I understand that my medical record is confidential and that I may refuse authorization to disclose all or some of the information contained therein, but that refusal may result in denial of coverage or claim for health benefits or other insurance.

I release Capital Foot Center, P.C., its employees, and John Tenny, D.P.M., Teresa Burnap, D.P.M., and Torrey Rassfeld, D.P.M. from any and all legal responsibility or liability that may arise from the act I authorized above.

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REASON PATIENT WAS UNABLE TO CONSENT

DATE

ASSIGNMENT OF INSURANCE BENEFITS

I assign to Capital Foot Center, P.C., John Tenny, D.P.M., Teresa Burnap, D.P.M., and Torrey Rassfeld, D.P.M. all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize direct payment of all such insurance benefits to Capital Foot Center P.C., John Tenny, D.P.M., Teresa Burnap, D.P.M., and Torrey Rassfeld, D.P.M. and agree to pay for any and all charges not paid pursuant to this agreement. I authorize the use of this signature on all insurance submissions.

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MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Capital Foot Center, P.C., John Tenny, D.P.M., Teresa Burnap, D.P.M., and Torrey Rassfeld, D.P.M. for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

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ALL SIGNATURE LINES MUST BE SIGNED BY THE PATIENT, OR BY THE PATIENT REPRESENTATIVE (IN CASE OF A MINOR, OR WHEN PATIENT IS PHYSICALLY OR MENTALLY UNABLE TO SIGN).