



Bay Area Podiatry Center

Patient Information Form

Date: _____

Name: _____ Date of Birth: _____

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

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Social Security Number: _____ Sex: M _____ F _____

Primary Care Doctor: _____ Phone: _____

Address: _____ City: _____ State: _____

Did Someone Refer You To Us? _____

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

Employer's Name: _____ Work Phone: _____

Name of Insured: _____ Insured Date of Birth: _____

Insured Social Security #: _____ Occupation: _____

Name of Insurance: _____ Phone: _____

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

ID# : _____ Group #: _____

Secondary Insurance: _____ Phone: _____

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

In Case Of Emergency Contact: _____

Phone Number: _____ Relationship: _____

Please present this form, your driver's license and all insurance I.D. cards to the receptionist at this time. Please read the following authorization and sign the form where indicated. I understand that I am responsible for all charges incurred whether or not paid by the above stated insurance. I hereby authorize this office to release any and all information necessary to secure reimbursement from any insurance company in which I have subscribed. I hereby authorize and direct payment to Bay Area Podiatry Center for the medical and/or surgical benefits, if any, otherwise payable to me under the terms of my insurance. I agree and understand that I may be charged 1.5% interest rate per month on any unpaid balance and that I am responsible for any cost incurred in collection of said balance should that become necessary. I have read and understand the above and agree to comply.

Signature: _____ **Date:** _____



Bay Area Podiatry Center

Health Information / Please Circle Yes or No

What Is Your Main 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 YES, PLEASE LIST) _____

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING?

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

Please List All Medications You Are Currently Taking: _____

DO YOU SUFFER FROM ANY OF THE FOLLOWING?

- Swelling Of The Feet, Ankles or Legs? YES NO
- Leg Cramps When Walking Or At Night? YES NO
- Enlarged Veins? YES NO
- Lower Back Pains? YES NO
- Tingling, Burning Or Loss Of Sensation In The Feet? YES NO

Signature: _____ **Date:** _____



Bay Area Podiatry Center

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 depend solely on what your specific insurance company offers to its members. Some insurance plans cover as little as 30 percent and some as much as 100 percent of your medical care, with most falling in the 50 to 80 percent range. Almost all plans (including PPOs, Medicare and Medicaid) exclude certain services that you may not be aware of.

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 percent 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 percent) of the U. C. R., which is defined as usual, customary and reasonable fees for this region.

If you are a member of a PPO plan, your co-payment is due at the time of service.

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 informed 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 that expected.

If you are a member of an insurance company we are not affiliated with, we ask that you pay the full amount of the visit at the time of service. Our staff will be happy to provide you with 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 cash, check, MasterCard, Visa and Discover. Returned checks are subject to a Twenty Five Dollar processing fee.



Bay Area Podiatry Center

Release and Assignment of Benefits

I, the undersigned, authorize payment of the medical and surgical benefits directly to Bay Area Podiatry Center and to release information including the diagnosis and the records of any such medical or surgical care.

I am also giving Bay Area Podiatry Center all rights to inquire on my behalf on any medical reviews relating to my medical benefits, either assigned or non-assigned claims.

SIGNATURE

DATE

In our attempt to better serve the needs of our patients, we have been forced to initiate our current policy of a forty dollar (\$40.00) charge for broken appointments without proper notice. We understand that a twenty-four (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 understanding and cooperation.

SIGNATURE

DATE



Bay Area Podiatry Center

If your benefit plan requires 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 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 parties. 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 carrier requires physician referrals, please understand that 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. Do not depend on our staff to keep track of your referrals for you.

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

SIGNATURE

DATE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), 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 payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Private Practices*.

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 you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Print Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date

Initials

Reason