PATIENT REGISTRATION

Patient Information

Name: ______________________, ______________ ___
Last First MI

Address: ______________________________
Street

______________________ ________ ____________
City State Zip

______________________ ______________________
Home Phone Mobile Phone

Pharmacy ______________________________

Date of Birth: ____ / ____ / ____ Age: ______

SSN: ________ - ______ - ________

Sex: M F Marital Status: S M D W

Name of Spouse: __________________________

______________________ ______________________
Emergency Contact Name Emergency Contact Phone

My Primary Care Physician (Family Doctor) is:

____

Patient's Employer

Employer: ______________________________

Occupation: ____________________________

Address: ______________________________

City ______________ State ______ Zip+4 ______

Work Phone: ____________________________

Primary Ins Company: ____________________

Secondary Ins Company: __________________

Please present Medical Insurance cards to receptionist

Patient's Spouse/Guardian/Guarantor

Name: ______________________________

Address: ______________________________

City: ______________ State ____ Zip ________

Primary/Mobile Phone: ____________________

Work Phone: ____________________________

SSN: _____ - ____ - _____ Date of Birth:___/___/___

Spouse/Guardian/Guarantor's Employer:

____

Occupation: ____________________________

Address: ______________________________

____

Phone: ______________________________

Assignment of Benefits

I hereby authorize the verification of my medical benefits and payments directly to the treating physician. I understand that I am responsible for any portion of my bill not covered by my insurance company.

______________________________ ____ / ____ / ____
Signature Date

Release of Information

I hereby authorize the treating physician to release any information required in the course of my treatment to my insurance company.

______________________________ ____ / ____ / ____
Signature Date

Authorization of Medical Treatment

I hereby consent and authorize the physician and any associates or assistants or consultants of his/her choice to provide medical treatment for the above patient.

______________________________ ____ / ____ / ____
Signature Date

FULL NAME:

Mr. / Dr. / Miss / Ms. / Mrs. ______________________________ Age: ______ Date: ____________

MEDICAL HISTORY

Do you HAVE or HAVE YOU HAD any of the following conditions?

	YES	NO
Diabetes	____	____
Heart disease	____	____
High blood pressure	____	____
Poor circulation	____	____
Arthritis	____	____
Kidney disease	____	____
Asthma	____	____
Stroke	____	____
Rheumatic fever	____	____
Hepatitis or liver disease	____	____
Sickle cell trait	____	____
Sickle cell anemia	____	____

	YES	NO
Blood clots (phlebitis)	____	____
Stomach disorder	____	____
Seizures or epilepsy	____	____
Abnormal or excessive bleeding	____	____
Difficulty healing	____	____
Keloid or Thickened scars	____	____
Gout	____	____
Swollen feet or ankles	____	____
HIV positive	____	____
Cancer: ______________________	____	____

Other condition(s) not listed: ________________

Do you have any ALLERGIES to any of the following?

	YES	NO	SENSITIVITY
Codeine	____	____	____
Demerol	____	____	____
Penicillin	____	____	____
Sulfa	____	____	____

	YES	NO	SENSITIVITY
Adhesive tape	____	____	____
Local anesthetic	____	____	____
Iodine Solution	____	____	____

Other drug allergies: ________________________

List ALL MEDICATION, including herbal products, you are currently taking: ______________________________

____

List Dates and Types of SURGICAL PROCEDURES you have had: ______________________________

____

Do you Smoke? YES / NO How much? ___________ / day

Weight: ______ lbs. Height: ___' ___" Shoe Size: _______

Have you had Previous Care by Another Doctor for your feet? YES / NO

What Is The Reason For Today's Visit? ______________________________

X ______________________________

Signature of Patient/Responsible Party

Assignment and Release/Financial Responsibility

What is a co-pay?
A co-pay is the small amount you have to pay to access medical care according to your insurance contract. In some cases it might be $5 - $60 but with some insurances, it would be a percentage of your bill (10% is common). This is supposed to provide a slight incentive for you to visit the doctor less and thereby avoid overuse of medical services. Medicare patients don't pay a co-pay "up front", but they are responsible for 20% of their bill.

What is a deductible?
A deductible is the amount of money that a patient must pay out of pocket before the insurance carrier is responsible for any charges. The average deductible ranges from $100 to $5000 and once this has been met the insurance company will begin to pay for covered services. Medicare patients are responsible for a $131 deductible at the beginning of each year.

Why do I have to pay my co-pay and/or deductible?
When you sign up with an insurance carrier, you sign a contract which stipulates that you are obligated to pay your co-pay and/or deductible, in certain instances. That means you are required to pay your co-pay or deductible for ALL office visits, including follow-up examinations, outpatient surgical procedures done in our office, etc.

Why do you collect the co-pay instead of billing me like my last doctor?
Co-pays are always due at the time of service and this policy is not something we can negotiate or change.

Why can't you just "write off" my co-pay and/or deductible?

1. Since your insurance "contract" stipulates that you must pay a co-pay and/or deductible, waiving this fee violates your contract.
2. When we sign up with your insurance company, we also sign a contract that says we will collect co-pays and/or deductibles as stipulated in our contract.
3. If the doctor gives you a discount by waiving your co-pay and/or deductible and then bills the insurance company without giving them the same "discount" it could be considered insurance fraud.

I, the undersigned certify that I (or my dependent) have insurance with ____________________ (name of insurance) and assign directly to Appling Podiatry, all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am personally responsible to pay all charges that are not covered by my insurance, including but not limited to co-pays, deductibles and non-covered services. I further understand I am responsible for any collection and or legal fees incurred in the collection of any past due charges.** I hereby authorize the doctors to release all information necessary to secure benefits, to continue medical care or to forward to a collection service. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature	Relationship	Date

Consent to Photography
I authorize Appling Podiatry to obtain and use photography as needed.

Responsible Party Signature	Relationship	Date

HIPAA I have read and understand the Privacy Policy Agreement for

Responsible Party Signature	Relationship	Date