PODIATRIC REGISTRATION AND HISTORY

Patient Information

Today's Date_____

Patient Name _____
Last
_____
First Middle
Address_____Apt_____

City_____

State_____Zip_____

Sex M___F___ Age_____

Birthdate _____

How did you hear about our office? _____

Insurance Information

Who is responsible for this account?

_____

Birth date/SSN of policy holder:

_____

Relationship to Patient:

_____

Patients SSN:

_____
Signature of Patient/Beneficiary

X_____

Phone Numbers

Home Phone (___)_____

Cell Phone (___)_____

IN CASE OF EMERGENCY,CONTACT

Name_____

Relationship_____

Home Phone(____)_____

Work Phone(____)_____

Physician_____

Last visit w/ PCP_____

Pharmacy Name_____

Pharmacy Phone(____)_____

Insurance Assignment and Release

I certify that I have insurance coverage with _____and assign directly to Dr.Teimouri all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named Dr may use my health care information and may disclosed such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services, This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare/Medigap Authorization

I request that payment of authorized Medicare benefits and , if applicable , Medigap benefits , be made either to me or on my behalf to Dr Teimouri, Beaver Valley Foot Clinic for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the centers for Medicare and Medicaid services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

With our Electronic Medical Records (EMR) system we have the potential ability to import a list of your medication history from SureScripts. If we can take advantage of this tool please sign consent:
I give consent to retrieve and use my medication history from SureScripts. _____ _____
Signature Date

Treatment Consent

I hereby consent and give my permission to the Dr (and the doctors assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

X_____X_____
Signature of Patient,Parent,Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent,Guardian or personal representative Relationship to Patient

Beaver Valley Foot Clinic Financial Policy

We are glad you have chosen our office for your health care needs. The doctors and staff strive to prescribe the best and up to date treatments possible.

Full payment is expected on the day medical service are provided unless you have health insurance coverage with a plan that we have a written agreement. Our financial policy offers you a number of payment options; which are cash, checks, and credit cards (Visa, Master Card, and Discover). Patients with insurance must pay your, when applicable: **DEDUCTABLE -** an amount you must pay first, out of your own pocket, each year before insurance will pay for any services; **CO-PAYMENT** - an amount you must pay each visit to a doctor; **CO-INSURANCE -** an amount which is usually a percentage of the fee that your insurance company will not pay. Deductibles, co-payment and co-insurance is your responsibility to pay by law. On treatment that involves laboratory fees (custom orthotics, diabetic shoes, etc.) that is not covered by insurance or the deductible have not been met, you may choose to pay 50% down and 50% when the product is dispense.

We will need to make a copy of the front and back of your insurance card at your initial visit. We expect you to inform us of any change in coverage that may occur and provide us with insurance card to copy at that time. If you have two or more insurance policies, it is your responsibility to inform us which policy is **Primary** (first) coverage, which policy is **Secondary** (second) coverage, and which policy is **Tertiary** (third) coverage. With each policy we may require the name, date of birth, address, phone number, and employer of the member who carries the policy.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due by the end of the month.

Contracted Insurance: If we are contracted with your insurance company we must follow our contract and their requirements. If you have a co-payment or deductible, you must pay that at the time of service. It is the insurance company that make the final determination of your eligibility. Some insurance plans require a referral and/or preauthorization from your primary care physician. You are responsible for obtaining the referral and/or preauthorization prior to your appointment or full payment will be expected for the medical services rendered.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in some cases. We will bill your primary insurances company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company and full payment will be expected for the medical services rendered.

Return Checks: There is a fee (currently $25.00) for any checks returned by the bank.

Past Due Balances: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency or attorney, you agree to pay all of the collection costs or fees which are incurred. In case of suit, you agree the venue shall be in Beaver, PA.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

Print Patient's Name: _____

Print Responsible Party: _____
(if not the patient)

Signature: _____ Date: _____

Beaver Valley Foot Clinic

"A Step Ahead in Podiatry Solutions"

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878.313.3339 Fax.
www.BVFOOTCLINIC.COM

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations (HIPPA)

I _____understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and can be provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature of Patient or Legal Representative Witness

Signature _____ **Date:** _____

How may we contact you:

Please check the boxes below for the methods in which our office may leave a message about your appointment or medical information:			
Method of Contact	**Which is your personal preference?** Number 1-7 or place an 'X'	**Appointment Information** ✓ Or X	**Medical Information** ✓ Or X
Home Phone			
Cell Phone			
Mobile Text			
Work Phone			
With Another Person			
Send via Mail			
Send via E-Mail/Portal			