Bay Area Podiatry Center

1149 Professional Park Drive
Brandon FL 33511
813-685-3668

Patient Information Form

Date: _______________

Patient Name: ______________________________________ **E-Mail:** ___________________

Address: ____
Street City State Zip

Home Phone: __________________________ **Cell Phone:** ____________________________

Social Security #:_________________________ **Date of Birth** ___/____/____ **Sex: M__ F__**

Did Someone Refer You? If Yes, Whom ____

Primary Care Doctor: _______________________________ **Phone:** ____________________

Pharmacy: ____ **Phone:** ____________________
Name City

Emergency Contact: _________________________________ **Phone:** ___________________

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

Name of Insurance: ________________________________ **Phone#** _____________________

Policy Holder's Name: _____________________________ **Date of Birth:** _____/____/______

Insurance ID# __________________________________ **Group #**_______________________

Secondary Insurance: ______________________________ **Phone#** _____________________

Policy Holder's Name: _____________________________ **Date of Birth:** ____/____/_______

Insurance ID# ___________________________________ **Group #** ______________________

Signature: ____ **Date:** ____/____/____
If Under 18 Legal Guardian Must Sign

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 were 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.

Health Information / Please Circle Yes or No

What Is Your Main Complaint? ____

How Would You Rate Your General Health? Poor Fair Good Excellent

Height: ________ Weight: _________ Shoe Size: ____________

Current / Former Smoker? ……………………… Yes No

Family History Of Diabetes? ……………….......Yes No

Are You Taking Blood Thinners? ………….......Yes No

Are you Sensitive to Latex?………………………Yes No

Have You Had ANY Previous Surgeries? ……… Yes No (If YES Please List Below)

____

Are You Allergic to ANY Medications? …………Yes No (If YES Please List Below)

____

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 (Inflammation of the Veins) ……… 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 Medicare) 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**

<u>NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT</u>

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