PATIENT INFORMATION

Name: ____

Address: ______________________ **City/State:** ______________ **Zip:** ________

Phone: (H) ______________ **(W)** ______________ **(C)** ______________

Date of Birth: ___________ **Social Security #:** ______________

Ethnicity: ____________ Are you of Hispanic Origin Y N Marital Status: S / M / W / D / SEP

Email: ____________________

Shoe Size: ________ Have any family members been seen in our office? Y N

If so, please list their names: ______________________________________

How did you hear about our office? Family/Friend Advertisement Physician

PRIMARY CARE PHYSICIAN

(PCP) Name: ______________________ PCP Phone #: ____________

PCP Address: ____

Are you Diabetic? Y N Referring Physician: ______________________

Pharmacy/Address: ______________________ Pharmacy Phone #: ___________

INSURANCE INFORMATION

Primary Insurance: ______________ **Insured:** __________ **Social Security #:** ________

Date of Birth: ______________ Insured's Relationship to Patient: ______________

Address: ____

Policy #: ______________________ Group #: ______________________

Primary Subscriber Employer: ______________________ Employer Phone #: ____________

Secondary Insurance: ______________ **Insured**: __________ **Social Security #:** ________

Policy #: ______________________ Group #: ______________________

EMERGENCY CONTACT INFORMATION

Emergency Contact/Name: ________________ Phone #: ____________ Relationship: ________

Emergency Contact/Name: ________________ Phone #: ____________ Relationship: ________

 © 2013

AP FINANCIAL POLICY

We would like to take this opportunity to welcome you to Advanced Podiatry. We appreciate your trust in us and our main concern is that you receive proper and optimal treatment. Please take this opportunity to review and sign our office Financial Policy. Our office staff will be happy to address any concerns you may have.

Insurance: Your insurance policy is a contract between you and your insurance company. Your benefits are determined by your insurance company and we will bill accordingly. If, after your insurance company pays a claim you have a balance with our office, please understand that the balance is determined by your insurance contract. We do not discount balances that your insurance company deems your responsibility.

Co-Payments, deductibles and co-insurance: All co-pays and deductibles as determined by your insurance contract must be paid at the time of service. If you are unable to pay your co-pay, we will be happy to reschedule your appointment.

Proof of Insurance: All patients must complete our patient information form before seeing the doctor. We will need a copy of your driver's license/picture ID and current valid insurance card(s) to provide proof of insurance.

Self-Pay Appointments: If you do not have insurance, we will be happy to see you on a self-pay basis. We require $150.00 prior to each visit. Your charges will be determined at the end of your visit based on what services/products the doctor has provided. If your balance is less than $150.00 at the end of your appointment, you will receive an immediate refund of the difference. If your charges are more than $150.00, you will be responsible for the remaining balance at checkout.

Minor Children: Any charges incurred on a minor child's account will be billed to the parent or legal guardian of the child. As such, we will need demographic information on the parent/guardian at the time of the child's visit. In the case of divorced parents, the parent bringing the child to his/her appointment will be responsible for any co-pays or balances even if that parent is not the primary subscriber to the child's insurance policy.

Durable Medical Equipment: We often use Durable Medical Equipment (DME) items as part of your necessary medical care. However, some insurance companies do not cover certain items and you will be responsible for the purchase. In the case of custom items, it is our policy to dispense those in the office in order to ensure proper fit. When the item is received in our office, we will contact you to schedule a fitting. Custom items are non-returnable.

Non-Covered Services: You are responsible for any non-covered services you choose to receive. You will be informed of any non-covered charges and must pay for them in full before receiving treatment. Non-covered services are determined by your insurance company and will not be billed to your insurance.

Non-Payment: After 90 days of non-payment, you will be contacted by phone regarding any outstanding balance. If we are unable to reach you within 10 days, your balance will be turned over to a collection agency.

NSF Checks: Restitution for returned checks is required within (5) working days with cash, money order or credit card and will be subject to a $25.00 returned check fee. If checks are not picked up within the allotted time, they will be turned over to the District Attorney for prosecution.

Forms and Documents: Completion of ALL outside forms such as disability applications FMLA paperwork etc., will be subject to a $10.00 fee. This fee is not billable to insurance and must be paid before you receive your completed paperwork from our office. Any request for records from our office may take up to 2 weeks to fulfill.

Medicare Patients: Our office accepts Medicare assignment, which means that you are responsible for the yearly deductible of $135.00 and the 20% co-insurance that Medicare allows. If your secondary insurance carrier does not cover co-pays/co-insurance, you will be responsible for the balance.

I have read, understood and have received a copy of the payment policy and I agree to abide by its guidelines.

Patient Signature: ______________________________ **Date** ______________________

Print Patient Name: ______________________________

ADVANCED PODIATRY, PLLC
15318 N. MAY AVE SUITE A
EDMOND, OK 73013 © 2013

ADVANCED PODIATRY

PATIENT HIPAA ACKNOWLEDGEMENT
DESIGNATION AND DISCLOSURE FORM

Acknowledgement of Practice's Notice of Privacy Practices:
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

____ ____

Print Name of Patient Date of Birth Signature of Patient/Guardian Date

Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain types of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only the information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Name: ____________________________________ Last four digits of his/her SSN/DOB (required): _________________

Name: ____________________________________ Last four digits of his/her SSN/DOB (required): _________________

Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home/Work/Fax Telephone Number: _________________ Written Communication Address: ______________________________

____ OK to leave message with detailed information ____ OK to mail to address listed above
____ Leave message with call back numbers only ____ E-mail me at: ____

The following person(s) are NOT authorized to receive my Patient Health Information (PHI):

Print Name: ___________________________________ Print Name: ____

The HIPAA Privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary health care activities related to providing patient treatment, obtaining payment for its services or its internal operations. Also, the Practice does not have to account for disclosures for which I have executed and Authorization permitting disclosures of my PHI.

The above authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive health care at the Practice. These Authorizations may be revoked at any time by notifying the Practice in writing at the Practices mailing address marked to the attention of 'Privacy Officer'.

The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation. I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.

1. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.
2. This authorization is valid as of the date I signed below and shall remain valid for a period of one year.

____ ____

Print Name of Patient **Signature of Patient** **Date**

 © 2013

ADVANCED PODIATRY

PATIENT NAME: ____________________________________

PHARMACY INFORMATION

Pharmacy: ____ Phone #: ______________________________

Address: ____

CURRENT MEDICATIONS

Medication Name	Strength	How Taken