Patient Information

Name (Last, First, M.I.):_____

If Minor, (Parent/Guardian):_____

Address: _____ Apt: _____ City, State Zip: _____

Phones: (Home) _____ (Cell) _____ (Work) _____

Age: _____ DOB: _____ Gender: M F SSN: _____

Race: _____ Ethnicity: _____ Primary Language: _____

Marital Status: Married Single Widowed Divorced Separated Email: _____

Employer: _____Occupation: _____ *If Student,* Full Time _____ Part Time _____

Spouse's Name: _____ Spouse's Employer: _____

Phones: (Home) _____ (Cell) _____ (Occupation) _____

Emergency Contact (Name/Relationship): _____ *Phone:* _____

Insurance Information

Primary Insurance: _____

Policy No.: _____ Group No.: _____

Subscriber (Name/Relationship): _____ (DOB) _____

Subscriber's (Address) _____ (SSN) _____

Subscriber's Phones: (Home) _____ (Work) _____

Secondary Insurance: _____

Policy No.: _____ Group No.: _____

Subscriber (Name/Relationship): _____ (DOB) _____

Subscriber's (Address) _____ (SSN) _____

Subscriber's Phones: (Home) _____ (Work) _____

Who may we thank for referring you to our office? _____

Please note: Payment for services is required at the time services are rendered unless prior arrangements have been made in advance. Regardless of insurance, ultimately, the patient or guarantor is responsible for all charges incurred. Also, some insurances may require prior authorization for services. Should this pertain to you, please verify with our receptionist to ensure this approval has been obtained *before* being seen by one of our physicians.

CONTINUE TO NEXT PAGE

Medical & Podiatric Information

Primary Care Physician: _____ City, State: _____ Date last seen: _____

Previous Podiatrist: _____ Date last seen: _____

Health History

(Check conditions that apply to you)	Yes	No			Yes	No
Diabetes				Mental Disorder		
Arthritis				Anemia		
High Blood Pressure				Tuberculosis		
Heart Disease				Circulation Problems		
Kidney Disease				Peripheral Vascular Disease		
Liver Disease				Bleeding Disorders		
HIV				Phlebitis		
Lung Disease				Blood Clots		
Thyroid Disease				Varicose Veins		
Neurologic Disease				Stroke		
				Cancer *(Including Skin)* Type: _____		

If any relatives (be specific) have or had any of the conditions listed above, please describe: _____

_____

Are you pregnant? Yes ____ No ____ *If yes, due date:* _____ Are you breastfeeding? Yes ____ No____

Alcohol Use? Yes ____ No ____ *If yes, how much?:* _____ Recreational drugs use? Yes ____ No ____

Tobacco Use? Yes ____ No ____ *If yes, how much and duration?:* _____

Have you been hospitalized in the past year? Yes _____ No _____ If yes, list the reason below: _____

_____

Are you taking medications *(List ALL)*? Yes _____ No _____ If yes, list them below: _____

_____

Do you have allergies? Yes _____ No _____ If yes, list them & reactions below: _____

_____

Preferred Pharmacy *(Include Phone & Location):* _____

Surgeries *(list all, including foot, ankle, & vascular)*: _____

_____

Reason for Visit *(Please specify about the nature, location, & duration of condition)*: _____

_____

Is this work or auto related?: Yes ____ No ____ If yes, give date of injury: _____

Patient's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

TALLAHASSEE PODIATRY ASSOCIATES, P.A.

INSURANCE AUTHORIZATION

This is to include both primary and secondary insurances which may include Medicare, Blue Cross Blue Shield, Capital Health Plan, United Health Care, Aetna, as well as many other medical insurances that are not listed.

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions.
I authorize release of information to all my insurance carriers.
I understand that I am responsible for my bill.
I authorize payment directly to my doctor.
I permit copy of this authorization to be used in place of the original.

Patient Name

Please Print

Signature

Date

Medigap Policy Number

TALLAHASSEE PODIATRY ASSOCIATES, P.A.

ABOUT FINANCIAL RESPONSIBILITY AND MEDICAL INSURANCE

We are committed to providing you with the best possible podiatric care. If you have medical insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policies.

Payment for services is due at the time services are rendered. We accept Cash, Checks, American Express, Discover, Visa, and MasterCard. If we are providers for your insurance company, we will file your claims for you, BUT you are responsible at the time of services for all co-pays and deductibles. It is your responsibility to know what those amounts are according to your contract with your insurance company. If we are not providers, we expect payment in full and will give you all the information needed to file your claims for reimbursement.

You must realize, however, that:

1. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract unless we have entered into a written agreement with your insurance company as a provider. An example:
    a. Medicare:
        i. The patient is responsible for all co-insurances and deductible amounts as outlined in the Medicare laws. Supplementary insurance will be accepted ONLY if it crosses over under the Medigap program. If not, the patient is responsible for all deductibles and 20% of Medicare's allowed amount.

2. Our fees are generally considered to fall within the acceptable range of most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage of U.C.R. amounts. "U.C.R." is defined as usual, customary and reasonable fees for a specific region. This does not apply to companies who reimburse on fee schedules.

3. Not all services are covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Therefore, the patient is responsible for these services. We also carry several items that are not paid for by our insurance company that are listed as non-covered supplies. These MUST be paid for at the time of purchase.

4. Returned checks are subject to additional collection fees.

5. Charges may also be incurred for appointments not cancelled 24 hours in advance and for broken appointments. THIS WILL ESPECIALLY APPLY TO SURGICAL SUITE RESERVATIONS.

We must emphasize that as podiatry care providers, our relationship is with YOU, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients if we are providers, all charges are your responsibility for the date services is rendered.

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES AND BALANCES DUE ON MY ACCOUNT FOR PROFESSIONAL SERVICES INCURRED AT TALLAHASSEE PODIATRY ASSOCIATES, P.A. I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED FOR ME.

Signature of Patient/Sponsor, Parent of Minor

Date

TALLAHASSEE PODIATRY ASSOCIATES, P.A.

Tallahassee Podiatry Associates (TPA) has provided me with the opportunity to review the Practice's Privacy Notice prior to my signing of this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) that is necessary for the practice to provide medical treatment, obtain payment and carry out its health care operations. A copy of the Privacy Notice is available to me now and in the future upon my request.

TPA reserves the right to change its privacy practices in accordance to applicable Federal and States laws.

I understand and consent to the following appointment reminders that may be used by TPA: a telephone call to the telephone number provided by me whether it is home, cell, or business. A message may be left on an answering machine or with the person answering the given number. The person calling will give the name of the practice or doctor's name, time, and date of the appointment.

I understand that TPA uses a fax machine to transit certain information pertinent to my care to HIPAA compliant entities, such as a doctor's office, insurance company, etc. If I request a fax be sent to a personal or business fax, I will sign a release.

I understand anyone picking up any information for me must have identification and authorization.

I understand TPA uses a sign in sheet for patients. It may be seen by others seeking treatment on the same day. There is no PHI required on the sign in sheet.

I understand that I have the right to request that TPA restricts how my PHI is used and disclosed to carry out treatment, payment and healthcare operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice does agree to a requested restriction, then the restriction is binding on the Practice.

I understand there are instances where no consent is required for TPA to disclose my PHI. Those are in accordance with Federal and State regulations and are listed in the Privacy Notice.

This consent is valid for seven (7) years. I further understand that I have the right to revoke this consent, in writing, any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance to the consent.

I understand that if I revoke this consent at any time, the practice has the right to refuse to treat me.

I understand that if I refuse to sign this consent evidencing my consent to the uses and disclosures described to me above and pertaining to the privacy, then the practice will NOT treat me.

I understand that I have the right to complain to the Practice's Privacy Officer if I feel my rights have been violated. All complaints must be in writing.

I have read and understand the forgoing notice and have had all my questions answered.

Name Of Patient (Printed)	**Signature Of Patient**
Signature Of Legal Representative (e.g. Legal Guardian, Parent, Etc.)	**Relationship**
Date Signed	**Witness**

TALLAHASSEE PODIATRY ASSOCIATES, P.A.