FLORENCE FOOT CENTER

PATIENT INFORMATION

First Name_____ MI_____ Last Name_____ Sex ☐ M ☐ F

Date of Birth_____ Age_____ Social Security #_____

Email_____ Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Address_____ City/State_____ Zip_____

Name of Employer_____ City/State_____

Are you a resident of a nursing home or assisted living facility? ☐ Yes ☐ No

If Yes, which one? _____

CONTACT INFORMATION

Home Phone_____ Cell Phone_____

May we leave messages for you regarding your protected health information? ☐ Yes ☐ No

Please indicate who we may speak with regarding your protected health information:

_____

In case of emergency, please contact:

Name_____ Relationship_____ Phone_____

PLEASE GIVE ALL INSURANCE CARDS TO RECEPTIONIST

RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE AND AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I hereby authorize Florence Foot Center to release any information necessary to process any insurance claim acquired in the course of my examination or treatment to allow a photocopy of my signature to be used to process my insurance claim. I claim, direct, and authorize my carrier to issue payment check(s) directly to Florence Foot Center, for any insurance benefits to which I am entitled. I understand that failure to disclose precertification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by my carrier. Regardless of insurance benefits, if any, I understand that I am fully responsible for any and all fees incurred, and I agree the above is a legal and lawful debt. If it becomes necessary to forward this account to collections, I agree to be responsible for any/all collection costs, attorney fees, and/or court costs. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state. I realize that in extraordinary circumstances, some insurance companies will not pay for certain procedures (i.e., MRI's or Ultrasounds). I understand that my insurance is filed as a courtesy and I am responsible for the bill.

Patient/Responsible Party Signature_____ Date_____

Patient Name_____ DOB_____

Reason for today's visit _____

Family Doctor/PCP_____ Pharmacy_____

Have you ever been under the care of a pain clinic/pain contract? ☐ Yes ☐ No

If yes, when and where? _____

Do you smoke? ☐ Yes ☐ Never ☐ Former Tobacco User # of years_____ Packs Per Day_____

Do you drink alcoholic beverages? ☐ Yes ☐ No Drinks per week_____

MEDICATIONS/ALLERGIES

Please list all medications that you are currently taking (prescription and non-prescription)

OR ☐ MEDICATION LIST GIVEN TO RECEPTIONIST

Are you allergic to any medications? ☐ Yes ☐ No Latex? ☐ Yes ☐No

Please list any medications you are allergic to and the reaction _____

_____

HEALTH HISTORY/PRIOR SURGERIES

☐Alzheimer's	☐Anemia	☐Anxiety	☐Arthritis
☐Asthma	☐Back Problem	☐Blood Clots/DVT	☐Chemical Dependency
☐Cholesterol Problem	☐Dementia	☐Depression	☐Diabetes
☐Emphysema/COPD	☐GERD	☐Gout	☐Heart Disease
☐High Blood Pressure	☐HIV/AIDS	☐Hepatitis	☐Kidney Disease
☐Kidney Failure/Dialysis	☐Liver Disease	☐Lupus	☐Neuropathy
☐Psychiatric Care	☐Sickle Cell	☐Stomach Ulcers	☐Stroke
☐Swelling/Edema	☐Tuberculosis	☐Shortness of Breath	☐Thyroid Disease

☐Cancer/Type_____

Other conditions/illnesses not listed_____

_____

<u>Please list all prior SURGERIES:</u>

Patient Name_____ Today's Date_____

I hereby certify by my signature that the medical information given on this form is correct to the best of my knowledge.

Patient Signature_____ Date_____

CONSENT TO TREAT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary. I also acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

X_____ Date_____

Signature of Patient, Parent, Guardian, or Personal Representative

_____

Please print name of Patient, Parent, Guardian, or Personal Representative/Relationship to patient

RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE. AND AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

Please Give ALL Insurance Cards to Receptionist

I hereby authorize Florence Foot Center, to release any information necessary to process any insurance claim acquired in the course of my examination or treatment to allow a photocopy of my signature to be used to process my insurance claim. I claim, direct, and authorize my carrier to issue payment check(s) directly to Florence Foot Center, for any insurance benefits to which I am entitled. I understand that failure to disclose precertification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by my carrier. Regardless of insurance benefits, if any, I understand that I am fully responsible for any and all fees incurred, and I agree the above is a legal and lawful debt. If it becomes necessary to forward this account to collections, I agree to be responsible for any/all collection costs, attorney fees, and/or court costs. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state. I realize that in extraordinary circumstances, some insurance companies will not pay for certain procedures (i.e., MRI's or Ultrasounds). I understand that my insurance is filed as a courtesy and I am responsible for the bill.

X_____ Date_____

Signature of Patient, Parent, Guardian, or Responsible Party

Financial Policy

Thank you for choosing Hames Foot Clinic to provide you with medical care. We are committed to serving you with skilled and high-quality care. The medical services provided by our office are services you have elected to receive, which may imply a financial responsibility on your part. You are welcome to decline any service or procedure or inquire about costs at any time during your visit.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Providing us with up-to-date information is your responsibility. **Knowing your insurance benefits is your responsibility**. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: Our office participates with Medicare. This means that we will send your claim to Medicare and we will adhere to Medicare's allowable fee schedule. Medicare sets an allowable fee for each service that they cover. After you have met your annual deductible, Medicare will pay us 80% of the allowable fee and you will be responsible for the remaining 20%. If you have a secondary insurance, this amount will be sent on to them and you will be billed for any remaining balance after their payment. **Patients are responsible for paying annual deductibles if it has not yet been met**.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance after payment and/or explanation of benefits (EOB) is received from your primary insurance company. If we have not heard from your secondary insurance within 60 days, you will be billed directly. In that event, you must contact the insurance company directly to find out why your claim has not been paid.

CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLES: All co-payments, co-insurance, and deductibles must be paid at the time of service. If not already collected, all co-pays, co-insurance and deductibles from prior visits will be due at the time of your next appointment. This arrangement is part of your contract with your insurance company.

SELF-PAY ACCOUNTS: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you may receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payments of these services at time of service.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for services received, unless your referral is presented at the time of visit.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the valance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: Occasionally after payment and/or explanation of benefits (EOB) are received from your insurance company/companies, there is a co-insurance or deductible that we were not aware of at the time of service. You will be sent three (3) notices of your financial responsibility. After the third and final notice, your account may be forwarded to collections. All cost incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office. Please let the billing office know if you have any difficulties resolving you bill. Payment arrangements can be made on a case-by-case basis. We accept the following payment methods: Cash, Check, Credit/Debit Card, and Care Credit.

COLLECTIONS: You agree, in order for us and any third-party collection agency to service your account or to collect any amounts you may owe, we may contact you by telephone at any number associated with your account including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or email, using any email address you provided to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing device, as applicable.

*An additional $35 will be added to your statement if the check is returned for insufficient funds (NSF).
*We can only file claims to your insurance company if you have completed our Patient Information Form. This includes having a complete medical history with current medications.

I have read the above policy regarding my financial responsibility to Hames Foot Clinic, Inc. for medical services provided. I agree to pay Hames Foot Clinic, Inc. any balance unpaid by my insurance carrier for myself or the below named person.
ASSIGNMENT OF BENEFITS:
I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Hames Foot Clinic, Inc. all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurances, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits, I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or request physician to provide continuity of care. I authorize the use of this signature on all insurance submission.

Patient Signature: _____ Date:_____
Financially Responsible Party Signature: _____ Relationship to Patient:_____ Date:_____