

**McConnellsburg PA location**

Dear \_\_\_\_\_

Welcome to our practice. An appointment has been scheduled for you at our office on:

Date: \_\_\_\_\_ **Registration time:** \_\_\_\_\_

**Appointment time:** \_\_\_\_\_ with Dr. \_\_\_\_\_

We hope that the following information will be helpful to you. We respect your time and we would like to make your visit to our office as efficient as possible.

**Location:**

214 Peach Orchard Road McConnellsburg, PA. Please plan to arrive at your registration time which is 20 minutes prior to your scheduled appointment in order to complete the registration process.

**Medical Information:**

We would appreciate if you would complete the enclosed Medical Information sheet. Please bring a current list of all your medication(s). If you have any previous podiatry or medical records such as x-rays, or MRI films of your feet it would be helpful to bring them with you.

**Financial Policy:**

We collect any patient portion, co-payment, or deductible at the time services are rendered. If you have any questions, please do not hesitate to contact our billing office at 301-739-1575 x 103. We accept Visa, Master Card, & Discover.

**Medical Insurance:**

Please bring a photo I.D., your current insurance card (s) and insurance referral form(s). This will help us file for insurance reimbursement on your behalf.

**Cancellation:**

A \$45.00 fee could be charged for any missed or rescheduled appointments within 24 hours of the scheduled appointment time. This fee must be paid in full prior to rescheduling your next appointment with our office.

If you have any questions regarding the above please do not hesitate to call our Hagerstown office at (301) 739-1575.

We look forward to meeting you.

Sincerely,

**Podiatry Associates of Hagerstown**

# PODIATRY ASSOCIATES OF HAGERSTOWN

Please update all information, sign, and return. Thank you.

PATIENT INFORMATION		Appt Date	Appt Time	Today's Date	Account #
Patient Name			Marital Status	Phone Message	
Street Address		Gender	Home Phone #	Work Phone #	
City, State, Zip			Date of Birth	Cell Phone #	
Today's Physician	Referred By	Primary Physician		Social Security #	

## GUARANTOR/FINANCIALLY RESPONSIBLE PARTY

Guarantor's Last	First Name	MI	Home Phone #
Address	City, State, Zip		Work Phone #
Employer	Employer's Address		

## PRIMARY INSURANCE INFORMATION

Insurance Company	ID #	Group #	
Address	City, State, Zip		Phone #
Policy Holders Name		Policy Holder Date of Birth	Social Security Number
Policy Holder's Employer	Patient's Rel. to Ins.	Visit Copayment	Insurance Effective Date

## SECONDARY INSURANCE INFORMATION

Insurance Company	ID #	Group #	
Address	City, State, Zip		Phone #
Policy Holders Name		Policy Holder Date of Birth	Social Security Number
Policy Holder's Employer	Patient's Rel. to Ins.		Insurance Effective Date

## AUTHORIZED PERSON TO CONTACT FOR BILLING OR RESULTS

Name:	Phone #:	Name 2:	Phone #:
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### 1. Financial Responsibility

I certify that the information I have provided regarding my insurance coverage is correct and authorize Podiatry Associates to verify insurance coverage and benefits allowed in accordance with my insurance plan's policies.

I authorize that payments be made directly to Podiatry Associates for all medical insurance benefits which are payable under the terms of my insurance policy for the services provided.

I agree to pay any copayments, coinsurance, or deductible as required by my insurance plan for medical care provided to me or my dependent I understand that I am responsible for knowing the terms and regulations of my insurance plan.

I agree to accept full responsibility for payment if my insurance coverage is not verified.

### 2. Release of Medical Information For Billing

I hereby authorize Podiatry Associates to submit a claim to my insurance company, health and welfare fund, Medicare or Medicaid for medical services provided to me or my dependent.

I also authorize Podiatry Associates to provide a copy of this release and a copy of medical records related to such services if requested by the payor. Further, I authorize Podiatry

Associates to release medical information to my consulting or primary care physician to assist with continuity of my health care. This release will expire one year from the date of my signature below unless I cancel this release in writing prior to that date.

### 3. Non-Covered Services

I agree to pay for medical services provided to me or my dependent which are not covered by the benefits in my insurance plan.

## I Agree to the Above Stated Responsibility and Consent

Signature of Patient or Legal Guardian	Date
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## Medication / Surgery List

Please list all medications you are currently taking including: aspirin, over the counter medications, herbal products and vitamins.

Medication	Dose	Frequency	Start Date	Stop Date
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				

Have you ever had surgery before? YES \_\_\_\_\_ NO \_\_\_\_\_

Have you ever been hospitalized? YES \_\_\_\_\_ NO \_\_\_\_\_

Please list all previous hospitalizations and surgeries:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Allergies: \_\_\_\_\_

**FINANCIAL POLICY Podiatry Associates of Hagerstown**

Thank you for choosing our offices to provide you with medical and surgical care. We are committed to serving you with skillful and high quality care. The medical/surgical services provided by our physicians are services you have elected to receive that may imply a financial responsibility on your part.

**COPAYS.** Co-pays are due at the time of service.

**SELF PAY.** Full payment or a minimum of \$100.00 is due at the time of service for those without health insurance benefits.

**MEDICARE.** We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. You are responsible for any co-payment or deductible amounts as stated by Medicare and your secondary insurance company on the day of your visit. .

**SECONDARY INSURANCE.** Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

**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 PCP prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your PCP at the time of the visit, a referral waiver will need to be signed, and payment for all services received will be due in full upon completion of the visit. Full credit will be given if a valid referral is presented to our office within 48 hours of this visit. You will be given the option to reschedule your appointment.

**MEDICAL/DISABILITY FORMS.** Please allow up to 3 business days to complete any Medical/Disability form. There is a pre-collect administrative fee of \$5.00 per form prior to completion.

**PATIENT BILLING.** You will receive three notices for your financial responsibility (co-insurance, deductible) after payment and /or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your balance and a \$20.00 processing fee will be forwarded to a collection agency. Please notify our billing office at **301-739-1575** if you have any difficulties resolving your bill. Payment arrangements can be made on a case-by-case basis. We accept the following payment methods cash, check or VISA/MasterCard. An additional \$25.00 will be added to your statement if your check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, please forward it to our office within 5 business days or you will be responsible for 100% of the charges.

**Cancellation Policy**

**A \$45.00 fee could be charged for any missed or rescheduled appointments within 24-hours of the scheduled appointment time.** This fee must be paid in full prior to rescheduling your next appointment with our office.

**PRIVACY STATEMENT.** Any information disclosed in your records will remain confidential. They will not be used for any reason except in providing quality care and treatment as well as to submit your claim to your insurance company.

I have read the above policy regarding my **FINANCIAL RESPONSIBILITY** to Podiatry Associates of Hagerstown for providing medical services to me or the below named patient. I agree to pay Podiatry Associates of Hagerstown any amount due after insurance payment has been made by my carrier and any contractual adjustments have been credited or the full amount of any bills incurred by me or the below named if no health insurance coverage exists.

**ASSIGNMENT OF BENEFITS.** I, the undersigned, certify that I (or my dependant) have coverage with my insurance as presented and assign directly to Podiatry Associates of Hagerstown all insurance benefits payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, missed appointment and /or non-covered services. I hereby authorize the doctor to release any information necessary to secure payment of benefits. I authorize **RELEASE OF MEDICAL INFORMATION** to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

**FINANCIALLY RESPONSIBLE PARTY:**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Please Print Signature

Podiatry Associates of Hagerstown

**Patient Name** \_\_\_\_\_ **Birth Date** \_\_\_\_\_  
 Last First MI  
 Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

**Reason for your visit:** \_\_\_\_\_  
 How long has this been a problem? \_\_\_\_\_ It occurs when? Morning Afternoon Evening Off and On All Day  
 Please list previous treatments (either prescribed or home remedies): \_\_\_\_\_

Percent spent daily on your feet: 20% 40% 60% 80% 100%  
 List sports/activities that you are currently active in: \_\_\_\_\_

\*\*\*\*Referred by: \_\_\_\_\_

**Medical History:** please circle **P** (personal history) and/or **F** (family history).

- |   |  |  |
|---|--|--|
| P F Alzheimer's Dementia  | P F Hearing Problems                   | P F Seizures / Epilepsy                  |
| P F Anemia – type_____  | P F Heart Disease                      | P F STD's                                |
| P F Arrhythmias – type_____   | P F Hepatitis A B C/Liver Disease_____ | P F Sickle Cell Trait/Dis                |
| P F Asthma circle (adult or childhood)                              | P F High Cholesterol                   | P F Thyroid problems<br>(Hyper__ Hypo__) |
| P F Blood Clotting Problems   | P F HIV/ Aids/ ARC                     | P F Tuberculosis                         |
| P F Cancer – type_____  | P F Kidney/ Renal Disease              | P F Other, Please Specify<br>_____       |
| P F Depression/ Anxiety disorder/<br>Bipolar depression/ other_____ | P F Lung Disease/ Pulmonary Embolus    | P F Other, Please Specify<br>_____       |
| P F Diabetes (how long? _____)                                      | P F Lyme's Disease                     | P F Other, Please Specify<br>_____       |
| P F Emphysema   | P F Nervous Condition (type?)_____     |  |
| P F Glaucoma  | P F Osteoporosis                       |  |
| P F Gout  | P F Phlebitis (blood clots in legs)    |  |
| P F GERD (Reflux) FI ulcers (circle)                                | P F Poor Circulation / PVD             | P F NONE of the above                    |
|   | P F Rheumatic Fever / Scarlet Fever    |  |

Do you have a history of allergies/ skin reaction/ sickness  
 Following the administration of any of the following:

	Y	N	** If yes, list REACTION
Adhesive tape	—	—	_____
Anesthesia	—	—	_____
Aspirin	—	—	_____
Caffeine	—	—	_____
Codeine	—	—	_____
Cortisone	—	—	_____
Demerol	—	—	_____
Foods	—	—	_____
Iodine	—	—	_____
Latex	—	—	_____
Local Anesthetics	—	—	_____
Penicillin	—	—	_____
Sulfa Drugs	—	—	_____
Other, please list:	—	—	_____

**Social History: PLEASE FILL OUT COMPLETELY SMOKING:**

Do you currently smoke? Yes No How many years? \_\_  
 How long does a pack of cigarettes last you? \_\_  
 Have you ever smoked? \_\_If yes for how long? \_\_  
 How long ago did you quit? \_\_\_\_\_

**ALCOHOL USE:**

Do you currently drink alcoholic beverages? Y N  
 Do you drink some form every day? Y N  
 How many will you consume in a day? \_\_week\_\_  
 Do you have a history of drinking? Y N  
 How long ago did you quit? \_\_\_\_\_

**RECREATIONAL DRUG USE:**

Do you currently use illicit/recreational drugs? Y N  
 If yes, which ones \_\_\_\_\_  
 Have you ever used illicit/recreational drugs? \_\_\_\_\_  
 How long ago did you quit? \_\_\_\_\_

**Woman:** Are you currently pregnant? Yes No Due date? \_\_\_\_\_

**Consent for Treatment:**

I certify that the information above is true and correct to the best of my knowledge. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance. I give permission to Drs. Harrison, Rosenthal, Smith and Roemer to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and ankles.

\_\_\_\_\_  
 Patient or Guardian Signature

\_\_\_\_\_  
 Date