



PLEASE COMPLETE THE FOLLOWING INFORMATION
PATIENT INFORMATION (Please Print)

DATE OF BIRTH / / AGE SOC. SEC # - -

PATIENT NAME: LAST FIRST MI SEX M / F

PARENT or GUARDIAN NAME(if Minor): LAST FIRST

HOME PHONE WORK PHONE CELL PHONE

RESIDENTIAL ADDRESS CITY STATE ZIP

Is this the primary address? yes no

EMPLOYER OCCUPATION

(Guardian's employer if a Minor)

EMPLOYER ADDRESS CITY STATE ZIP

NAME OF SPOUSE SPOUSE SOC. SEC # SPOUSE DOB

SPOUSE EMPLOYER SPOUSE EMPLOYER PHONE

Is Spouse, Parent, or other relative responsible for Bill? YES NO

EMERGENCY CONTACT NAME PHONE #

INSURANCE SUBSCRIBER NAME RELATIONSHIP

INSURANCE COMPANY

ID# GROUP#

ADDRESS CITY STATE ZIP

SECONDARY INSURANCE COMPANY

ID# GROUP#

ADDRESS CITY STATE ZIP

IS THIS A WORKERS COMPENSATION CLAIM? YES / NO If yes Claim #



Signature Page

AUTHORIZATION/RESPONSIBILITY AGREEMENT - AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:

I HEREBY AUTHORIZE THE DOCTORS OF THE ADVANCED FOOTCARE, INC. FACILITY TO RELEASE TO ANY INSURANCE COMPANY, OR THEIR REPRESENTATIVE, ANY INFORMATION, INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE PERIOD OF SUCH MEDICAL OR SURGICAL CARE NECESSARY TO PROCESS MY INSURANCE CLAIMS.

SIGNATURE _____ Date _____

INSURANCE – Assignment of benefits

AUTHORIZATION OF INSURANCE BENEFITS AND SERVICES RENDERED ON ACCOUNT:

I hereby authorize my insurance company to pay directly to Advanced Footcare, Inc for any and all medical, surgical fees, and/or DME otherwise payable to me for professional services. I understand that services rendered by the above named facility will be billed to my insurance company as a courtesy to me, but that I am personally responsible and liable for any and all surgical and/or medical fees billed. I understand that according to the requirements of my insurance plan, that it is my responsibility to pay for any and all deductibles, co-pay and coinsurance expenses as well as any service deemed not covered by my insurance at the time services are rendered. I am aware that I will be billed for amounts my insurance determines are patient responsibility on the Explanation of Benefits. Accounts will be considered late after 30 days and subject to late fees and/or collection fees. In the event the above named facility is required to retain the services of an attorney/collections agency to collect their bills, I agree to pay the above named facility fees of through and including appellate fees.

SIGNATURE _____ Date _____

MEDICARE – Assignment of benefits

MEDICARE PATIENT'S ONLY:

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for Medicare Allowable services and DME be made to the above named practice. I understand that Medicare will only pay for services that it determines to be "REASONABLE AND NECESSARY" under section 18629(a)(1) of the Medicare law. If Medicare determines that a particular service, although the otherwise covered, is "NOT REASONABLE AND NECESSARY" under Medicare program standards, Medicare will deny payment for that service. I understand that, by law, I am responsible for denied services, as well as for my health insurance DEDUCTIBLES AND CO-INSURANCE and that payment is due at the time of service, unless other arrangements are made. Late accounts may be subject to late fees and/or collection. I have read the above statement in understand that in the event the Medicare payment denial, I will be fully responsible for payment and services rendered.

SIGNATURE _____ DATE _____

Self- Pay

I understand the payment is due at the time of services, unless other, prior arrangements are made. If payment is not received within 30 days, accounts are considered LATE and may be subject to late fees and/or collection fees.

SIGNATURE _____ DATE _____

Patient Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of Advanced Footcare, Inc’s “Notice of Privacy Practices” as required by Federal law (HIPAA)

SIGNATURE _____ DATE _____

Appointment Policy

Notice: We now charge a \$25.00 NO SHOW FEE to patients who do not give us at least 24 of the need to cancel or reschedule their appointment. Please understand that we are trying to make sure that appointment slots are available to those patients who need to see the Doctor. Failure to show means another patient cannot see the doctor during the time reserved specifically for your appointment.



PATIENT CONSENT

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that will be used by the practice, a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for the treatment, and as necessary for the Practice to conduct its specific health care operations.

I understand that I have a right to request that the Practice restrict how my PHI is used and /or disclosed to carry out treatment, payment, and/or health care operations. However the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at 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 on this 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 do not sign this consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative
(e.g., /attorney-In-Fact, Guardian, Parent of Minor)

Relationship

Witness:

Date signed: ___/___/___



Advanced Footcare Financial Policy

This financial policy contains important information about billing and payment for our professional services. It outlines your responsibility as the patient and our responsibilities with regards to billing and payment for our services

- Our practice participates with many health insurance companies. Our business office will submit the claim for any service rendered to a patient who is a member of one of these plans. It is the patient's responsibility to provide us with current insurance information and to confirm that our doctors are participating in their insurance plan at time of service. The burden of proof is the patient responsibility and not the physician responsibility.
If a patient is a member of an insurance plan with which we do not participate, our office will also file the claim on the patient's behalf, if requested. However, the patient is expected to make payment in full at time of service.
It is the patient's responsibility to make payment at the time of services for any co-payment, deductible, or co-insurance due. Any services not covered by a patient's insurance plan are the patient's responsibility and payment in full is expected at time of services.
It is the patient's responsibility to ensure that any required authorization or referral for treatment is provided prior to the visit. In the absence of a required authorization or referral, the patient's visit may be rescheduled or the patient may be personally responsible for payment for the services rendered by AFC.
AFC charges financial fee of \$50 for each check returned for insufficient funds
If you request the completion of medical forms or a special letter from the physician, we may charge an administrative fee of at least \$25 per form.
Please understand that when you do not cancel an appointment you are unable to keep, it may prevent other patients from receiving care they need. Therefore, AFC charges a fee of \$25 for appointments not canceled with 24 hours notice.
Payment for professional services can be made by cash, check, credit card, or debit card.

Insurance & Insurance Collections:

Please understand that insurance reimbursements can be a long and difficult process for our office. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 60 days, the balance of your account will be due. It is the patient responsibility to make sure the insurance reimburses the physician for services rendered. Unresolved balances may be placed with an outside collection agency. These unresolved balances may also be subject to finance charges, attorney fees and collection agency fees. Once an account has been placed for collections, future appointments may not be made until you see or talk to a representative in our billing office, but emergency care will still be rendered. In the even of personal financial hardship, we are able to offer special financial arrangements.

Non-Contracted of Indemnity Insurance Plan:

Payment is due at time of service. Our office as convenience and a service to you, will absorb all cost incurred for billing and file the claim with your insurance company. Your insurance company will reimburse you directly for any payments you made to our office.

HMO Plans: All co-pays must be satisfied for each and every visit. There can be no exceptions due to contracting and compliance rules and regulations. You are responsible for getting proper referral information in advance of your appointment.

PPO Plans: Our office as a convenience and a service to you, will absorb all cost incurred for billing and filing that claim with your insurance. We have agreed to the discounted rate from your plan; however all co-insurance is your responsibility. We will estimate balances to the best of our ability.

MEDICARE: As participating provider, we will bill your Medicare carrier. You are responsible for your 20% co-payment and we must collect it each and every visit.

Secondary Insurers: Having more than one insurance, DOES NOT necessarily mean that your services are covered at 100%. Secondary insurances will pay as a function of what your primary carrier pays. We will bill your secondary carrier as a courtesy. You are responsible for any balances after your insurance(s) has cleared.

Interest & Rebilling Fees: We are not a billing company. We reserve the right to charge interest in the amount of 8% as provided by state law. Or, at our option, we may charge a rebilling fee of \$20.00 per bill.

This is to acknowledge that I have read and received a copy of the Advanced Footcare Financial Policy

Signature of Patient

Print Name

Date