WELCOME TO OUR OFFICE

Our goal is to provide the community with the highest quality and most comprehensive foot and ankle care possible. We strive to promptly address all of your podiatric concerns in the most courteous and relaxing manner possible during your visit.

The Foot Clinic Welcomes _____

Dr. Jonathan Purdy has extensive training in all aspects of medical and surgical treatment of the foot and ankle. Patient treatments range from simple nail conditions to reconstructive surgery. We treat all age groups, and any level of athletic performer.

Our doctors continually attend conferences throughout the country to train and certify in some of the latest techniques, using state-of-the-art technologies to help keep you on your feet pain free. Our goal is to make your visit as stress free and comfortable as possible.

Our Expertise Includes

- Heel Pain
- Corns and Calluses
- Bunions
- Hammertoes
- Ingrown and Fungal Nails
- Diabetic Foot Care
- Fractures and Sprains
- Sports Injuries
- Pediatric Foot and Ankle Conditions
- Geriatric Foot and Ankle Conditions
- Arthritis
- Pathologic Foot and Ankle Conditions
- Skin Disorders of the Lower Extremity
- Ulcers
- Reconstructive Foot and Ankle Correction

1100 Andre Street, Suite 202 New Iberia, La. 70563
Phone: 337-256-8494 Fax: 1-855-TWO-FEET(896-3338)

Patient Information for
The Foot Clinic, Dr. Jonathan Purdy
(please print)

Last Name: _____ First Name:_____ Middle Initial: _____ Today's Date:_____

Sex: [ ] Male [ ] Female **Marital Status:** [ ] Single [ ] Married [ ] Other **Student:** [ ] F/T [ ] P/T **Primary Language:** _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Social Security #: _____ Email: _____ @ _____

Were you referred here? [ ] Yes [ ] No **Reason for visit?** _____

Primary Care Physician: _____ **Primary Care Physician Phone:** _____

Primary Pharmacy Used: _____ **Pharmacy Phone:** _____

Race: [ ] White [ ] American Indian or Alaskan Native [ ] Black (African American) [ ] Asian **Ethnicity:** [ ] Hispanic [ ] Not Hispanic or Latino

Smoking: [ ] Every Day [ ] Some Days [ ] Former Smoker [ ] Never Smoked [ ] Smoker Unknown Status [ ] Unknown if Ever Smoked

Place of Employment: _____ **Occupation:** _____

Guarantor: *(Person responsible for the patient's portion of the bill)* ☐ **Self**

Name: _____ Relationship: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contacts: *(Please list two (2) – one that does NOT live with you)*

1. Name: _____ Relationship: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

2. Name: _____ Relationship: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Insurance: _____

Subscriber ID#: _____ Group ID#: _____

Effective Date of Coverage: _____

Primary Insurance Address: _____

_____

Primary Insurance Phone: _____ **Insured:** [ ] Self [ ] Spouse [ ] Child [ ] Other: _____

Insured's Name (***if other than self***): __ _____ Insured's Date of Birth: _____

Insured's Social Security #: _____ Insured's Place of Employment: _____

Insured's Employment Phone #: _____

****

Secondary Insurance: _____

Subscriber ID#: _____ Group ID#: _____

Effective Date of Coverage: _____

Secondary Insurance Address: _____

_____

Secondary Insurance Phone: _____ **Insured:** [ ] Self [ ] Spouse [ ] Child [ ] Other: _____

Insured's Name (***if other than self***): __ _____ Insured's Date of Birth: _____

Insured's Social Security #: _____ Insured's Place of Employment: _____

Insured's Employment Phone #: _____

PATIENT HISTORY

*** Please fill out all forms to the best of your ability. The staff will go over the form and answer any questions you may have.**

Name: _____ Date: ___/___/___

Age: _____ Height: _____ Weight: _____ Shoe Size: _____

1) What is the main problem with your feet or ankles? _____

_____

2) When did you first notice the condition? _____

3) Is this an injury? ____Yes ____No If Yes, when did it occur? ____/____/____

If Yes, did it happen at work? ____Yes ____No Are you claiming Workman's Comp? ____Yes ____No

4) Check all of the following that apply:

Type of Pain ___Burning ___Tingling ___Sharp ___Dull Ache ___Throbbing
___Shooting ___Stabbing ___Numbness

When Painful ___Upon Standing ___During Walking ___After Walking
___During Sports ___Worse with Activity ___Better as Activity Continues
___Worse when standing ___With Shoes ___Without Shoes
___A.M ___P.M ___Lying in Bed ___Always

5) How painful is your condition? If **0** = "no pain" and **10** = "the worst pain you have ever experienced", please circle your pain level: **0 1 2 3 4 5 6 7 8 9 10**

6) How has this affected your daily routine and what activities does this keep you from performing? _____

_____

7) Have you had foot care before? ____Yes ____No By whom and when: _____

_____

MEDICATIONS

Pharmacy: _____ Number: _____-_____-_____

Medication	Dosage	How Often Taken?	What is it Taken for?

ALLERGIES

☐ NONE ☐ OTHER _____

☐ Penicillin ☐ Sulfa ☐ Iodine ☐ Aspirin ☐ Anesthetics ☐ Latex

☐ Codeine ☐ Demerol ☐ Darvocet ☐ Cortisone ☐ Environmental ☐ Food

Type of Reactions:_____

MEDICAL HISTORY

* Please check any of the following conditions that you have or have had in the past.

☐ Diabetes ☐ Fibromyalgia ☐ Tumors ☐ Epilepsy ☐ Nerve Conditions ☐ Heart Problems

☐ Arthritis ☐ Gout ☐ Asthma/COPD ☐ Glaucoma ☐ Stomach Ulcers ☐ Skin Disorders

☐ Tuberculosis ☐ Anemia ☐ Bursitis ☐ Aids (HIV) ☐ Lung Disease ☐ Kidney Problems

☐ Sickle Cell ☐ Stroke ☐ Hepatitis ☐ Osteoporosis ☐ Bleeding Problems ☐ Colitis / Crohn's

☐ Mental Disorders ☐ Poor Circulation ☐ High Blood Pressure ☐ Joint Implants ☐ Thyroid Disease

☐ Rheumatic Fever ☐ Heart Burn / Reflux ☐ Sexually Transmitted Diseases ☐ High Cholesterol

☐ Cancer; type _____ Other: _____

☐ Diabetes; What is the name, phone number, and address of the doctor treating you for diabetes? _____

_____

When was your last visit? ____/____/____ What is your average blood sugar reading? _____

- Are you pregnant? ____Yes ____No How many months? _____

SURGICAL HISTORY

Procedure	Date	Complications

7) Have you ever been hospitalized other than for surgery? ____Yes ____No Explain_____

_____

8) Have you ever had an injury to the lower extremity? ____Yes ____No Explain _____

_____

FAMILY HISTORY

* Please check all that apply

	FATHER	MOTHER	BROTHER	SISTER
Diabetes				
Heart Disease				
High Blood Pressure				
Arthritis				
Gout				
Thyroid				
Cancer (what type)				
Other				

SOCIAL HISTORY

Date of last physical Exam: ____/____/____ Occupation:_____

Activities: _____

Level of activity: ____Occasional ____Weekly ____Competitive ____Professional

Do you smoke tobacco? ____Yes ____No

If Yes: # packs per day? ____ # cigarettes per day? ____ # of years smoking? ____

If No: Did you ever smoke? ____Yes ____No

If Yes: How long ago did you stop smoking? _____

Do you drink alcohol? ____Yes ____No

If Yes: How much? ____< 1 per week ____1-2 per week ____1-2 per day ____more than 3 per day

Recreational drug use

* Any type of drug use is a personal choice and will in no way adversely effect your relationship with the doctor. However, many drugs can interact with other medications and treatments with potential life threatening effects. Therefore, it is extremely important that you answer honestly. Your response will be held in the most strict patient-doctor confidentiality.

Answer: ____Yes ____No

If Yes: What substance and how often used? _____

REVIEW OF SYSTEMS

*If you are experiencing any of the following please circle

Head: chronic headaches, concussions, dizziness, loss of consciousness. **Eyes:** glasses, contacts, double vision, blurred vision, blindness, cataracts. **Ears**: decreased or loss of hearing, ringing in the ears, chronic earaches. **Nose:** drainage or infection, blockage, bleeding, sinusitis. **Throat**: chronic tonsillitis, laryngitis, difficulty swallowing, loss of speech. **Cardiovascular:** chest pain, shortness of breath, palpitations, murmurs, heart valve disease, anemia, leg cramps. **Respiratrory:** bronchitis, pneumonia, difficulty breathing, wheezing, chronic cough. **Gastointestinal:** nausea, vomiting, diarrhea, constipation, weight gain or loss, blood in stool, black stool, excessive gas, loss of appetite. **Genitourinary:** chronic kidney or bladder infections, problems voiding, pain with urination, dark or bloody urine, discharge from penis or vagina. **Gynecologic:** Irregular or painful periods, absence of period if not in menopause, vaginal discharge.

Other: _____

- Do your legs swell? ____Yes ____No
- Do you have back problems or have had a back injury? ____Yes ____No

☐ **I am not experiencing any of the above symptoms.**

NOTICE OF PRIVACY PRACTICES (HIPAA REGULATIONS)

☐ You were provided with a document entitled "Notice of Privacy Practices." It is required by governmental regulations that all medical facilities provide you with this notice. Please check the box to acknowledge that you have read (or had the opportunity to read if you chose) and understand the notice. This is a copy of the notice that is yours to keep. If you do not want the copy, simply return it to the receptionist with your other materials.

CONSENT

I certify that the information above is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures, including therapeutic and diagnostic injections, as may be deemed necessary in the diagnosis and/or treatment of my feet.

How did you hear about us? Circle one

Internet Friend/Family Lifestyle Billboard Referral Phonebook

Insurance Other_____

Signature: _____ **Date: ____/____/____**

The Foot Clinic

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Foot Clinic (the "Practice"), in accordance with the federal Privacy Rule, 45 CFR parts 160 and 164 (the "Privacy Rule") and applicable state law, is committed to maintaining the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice and is often referred to as your health care or medical record. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

(a) **Treatment** – To provide you with the health care you require, the Practice may use and disclose your PHI to those health care professionals, whether on the Practice's staff or not, so that it may provide, coordinate, plan and manage your health care.

(b) **Payment** – To get paid for services provided to you, the Practice may provide your PHI, directly or through a billing service, to a third party who may be responsible for your care, including insurance companies and health plans. If necessary, the Practice may use your PHI in other collection efforts with respect to all persons who may be liable to the Practice for bills related to your care. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) **Health Care Operations** – To operate in accordance with applicable law and insurance requirements, and to provide quality and efficient care, the Practice may need to compile, use and disclose your PHI. For example, the Practice may use your PHI to evaluate the performance of the Practice's personnel in providing care to you.

OTHER EXAMPLES OF HOW THE PRACTICE MAY USE YOUR PROTECTED HEALTH INFORMATION

(a) **Advice of Appointment and Services** – The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders may be used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

(b) **Family/Friends** – The Practice may disclose to a family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

(i) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.

(ii) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

OTHER USE & DISCLOSURES WHICH MAY BE PERMITTED OR REQUIRED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

(a) **De-identified Information** – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

(b) **Business Associate** – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

(c) **Personal Representative** – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) **Emergency Situations** – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) **Public Health Activities** – The Practice may use and disclose PHI when required by law to provide information to a public health authority to prevent or control disease.

(f) **Abuse, Neglect or Domestic Violence** – The Practice may use and disclose PHI when authorized by law to provide information if it believes that the disclosure is necessary to prevent serious harm.

(g) **Health Oversight Activities** – The Practice may use and disclose PHI when required by law to provide information in criminal investigations, disciplinary actions, or other activities relating to the community's health care system.

(h) **Judicial and Administrative Proceeding** – The Practice may use and disclose PHI in response to a court order or a lawfully issued subpoena.

(i) **Law Enforcement Purposes** – The Practice may use and disclose PHI, when authorized, to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena, or if the Practice believes that your death was the result of criminal conduct.

(j) **Coroner or Medical Examiner** – The Practice may use and disclose PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(k) **Organ, Eye or Tissue Donation** – The Practice may use and disclose PHI if you are an organ donor to the entity to whom you have agreed to donate your organs.

(l) **Research** – The Practice may use and disclose PHI subject to applicable legal requirements if the Practice is involved in research activities.

(m) **Avert a Threat to Health or Safety** – The Practice may use and disclose PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(n) **Specialized Government Functions** – The Practice may use and disclose PHI when authorized by law with regard to certain military and veteran activity.

(o) **Workers' Compensation** – The Practice may use and disclose PHI if you are involved in a Workers' Compensation claim to an individual or entity that is part of the Workers' Compensation system.

(p) **National Security and Intelligence Activities** – The Practice may use and disclose PHI to authorized governmental officials with necessary intelligence information for national security activities.

(q) **Military and Veterans** – The Practice may use and disclose PHI if you are a member of the armed forces, as required by the military command authorities.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

You have the right to:

(a) Revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request special restrictions on certain uses and disclosures of your PHI as authorized by law. In general, this relates to your right to request special restrictions concerning disclosures of your PHI regarding uses for treatment, payment and operational purposes under Privacy Rule, Section 164.522(a) and restrictions related to disclosures to your family and other individuals involved in your care under Privacy Rule, Section 164.510(b). Except in certain instances, the Practice may not be obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c) Receive confidential communications or PHI by alternative means or at alternative locations as provided by Privacy Rule Section 164.522(b). For instance, you may request all written communications to you marked "Confidential Protected Health Information." You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and copy your PHI as provided by federal law (including Privacy Rule, Section 164.524) and state law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

(e) Amend your PHI as provided by federal law (including Privacy Rule, Section 164.526) and state law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by federal law (including Privacy Rule Section 164.528) and state law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

(g) Request special authorization to allow the Practice to use and disclose your protected health information (PHI) for purposes other than those enumerated in this Notice of Privacy Practices (NPP). This request must be made in writing to the Practice's Privacy Officer.

(h) Receive a paper copy of this Privacy Notice from the Practice (as provided by Privacy Rule Section 164.520(b)(1)(iv)(F)) upon request to the Practice's Privacy Officer, or from this Practice's web site [Your Web Site].

(i) Complain to the Practice or to the Secretary of HHS (as provided by Privacy Rule Section 164.520(b)(1)(vi)) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions you want answered about your privacy rights (as provided by Privacy Rule Section 164.520(b)(2)(vii)), you may contact the Practice's HIPAA Compliance Officer as follows:

The Foot Clinic
c/o HIPAA Compliance Officer
1100 Andre St, suite 202
New Iberia, LA 70563
The Foot Clinic

PRACTICE'S REQUIREMENTS

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of September 16th, 2011.

The Foot Clinic

1100 Andre Street
Suite 202
New Iberia, LA 70563

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!!

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Jonathan B. Purdy, DPM (**DBA "The Foot Clinic")**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Fund raising. Unless you request us not to, we will use your name and address to support our fund raising efforts. If you do not want to participate in fund raising efforts, please check off the following box.

- ❑ **Please do not use my information for fund raising purposes.**

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

The Foot Clinic Duties:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the **Privacy Officer**.

Complaints & Contact Person

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

The Foot Clinic
ATTN: Privacy Officer
1100 Andre Street
Suite 202
New Iberia, LA 70563

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

_____ _____

Patient Name (*Please Print)* Patient Signature

Date:_____

PATIENT FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you. Your complete understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.

I PLAN TO MAYKE PAYMENT OF MY MEDCIAL EXPENSES AS FOLLOWS: ☐ CASH ☐ CHECK ☐ CREDIT CARD

As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. We will also keep track of necessary documentation, referrals, and pre-certifications you will need to be treated at our office. However, as our patient, you are ultimately responsible for all authorizations/referrals needed to seek treatment in this office. You must inform the office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied. Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. If you are undergoing a surgical procedure, Insurance out of pocket for surgery fees are required prior to surgery. If not covered by insurance, payment is expected in full. It is expected that all fees be paid in full within 90 days of the date of surgery whether you insurance payment has been received or not. Pre-certification of surgical procedures will be done as a courtesy to you; however, it is ultimately your responsibility to notify your insurance carrier prior to any surgical procedure.

Your insurance policy is a contract between you and your insurance company. If your insurance company does not pay the practice within a 90 day period following an office visit, you will be responsible for any unpaid balance. We have made prior arrangements with most insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service. "Usual and customary" rates may be different from charges for services rendered. You will be responsible for payment of any differences without regard to insurance determination of usual and customary or similar type coverage by insurance carrier(s). In addition, you agree not to delay on payment due to personal bankruptcy and or attorney advisement to not pay on the account nor any court action including and not limited to worker's compensation cases or injuries.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you are mainly responsible for charges of any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

If you are Medicare eligible, a claim will be filed on your behalf for covered services. We will file claims for non-covered services upon request.

The responsibility for payment of services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office.

Any credit balances on a patient's account will be applied to any unpaid balances. Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office. There is a service fee of $30.00 for all returned checks. Your insurance company does not cover this fee. A fee may be charged if you fail to cancel your appointment within 24 hours and/or do not show for your appointed time. In addition, all unpaid balances 91 days past due will incur interest of 1.5% per month which will be applied from day 31 from the date of service until the balance is paid in full. All payments are due by the tenth (10^{th}) day of each month. Thank you for you understanding or our Financial Policy.

I authorize treatment of the person named below and agree to pay all fees and charges for me and my family shown by statements promptly upon presentation thereof unless credit arrangements are agreed in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. I fully understand all terms and conditions, and this has been fully explained to my / our satisfaction, and I/we have completely read this financial agreement and authorization for treatment.

AUTHORIZATION AND ASSIGNMENT

I authorize the Foot Clinic to release medical information that may be necessary to request claim reimbursement from insurance companies to process my claim(s). I also authorize claim payments including major medical benefits to be made to the Foot Clinic I understand that I will be refunded any overpayment. I understand that I am ultimately responsible for payment of my account and if this assignment or claim is rejected, it will be my responsibility to pay any unpaid charges in full.

I authorize the Foot Clinic to secure whatever information regarding any claim to any insurance company doctor he feels necessary in assisting me in reaching its settlement or understanding of certain aspects of its settlement. This authorization and assignment may be revoked by me at any time by a written notice.

I agree a photocopy of this for may be used in lieu of the original.

_____ Date: ____/____/____

Signature of Patient/Responsible Party:

Printed Name: _____

_____ Date: ____/____/____

Witness:

Printed Name: _____