Birmingham Podiatry Patient Update

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip Code: _____

Telephone Number: _(_____)_____ Email: _____

Pharmacy Name: _____ Pharmacy Number/City: _____

Emergency Contact Name & Relation: _____ Number: _____

Primary Care Doctor: _____ Date Last Seen: _____

I N S U R A N C E :

** If your insurance has changed since your last visit with us, please give your new card to the front desk! **

Primary Insurance: _____

Secondary Insurance: _____

◦ What brings you in today? _____

_____

Is this due to an injury? (YES) (NO)

If yes, what was the date of injury? _____

** By signing below, I attest that I am agreeing that all information above is correct and I give permission for the doctor and clinical staff to administer and perform agreed upon procedures, injections, and x-rays that the Podiatrist deems necessary. I also agree that I am responsible for all charges not paid by my insurance company.

◦ Since you last visit to our office, have you had any changes in your medical history? (YES) (NO)

If yes, please note here: _____

_____

◦ Are you diabetic? (YES) (NO)

What was your last A1c? _____

Date A1c was last taken: _____

What was your last Blood Sugar: _____

◦ Since your last visit to our office, have you started or stopped any medications? If so, list them:

_____

_____

_____

_____

_____

Signature: _____

FINANCIAL POLICY

Thank you for allowing us the opportunity to serve you. Our goal is to provide you with high quality Podiatry care and a great experience with our practice. With that in mind we want to let you know up front that there are times when your insurance may not cover charges associated to your care. Please read the following to better understand your financial responsibility.

Insurance: We participate in most insurance plans. If you are not insured by a plan we participate with, or do not have insurance at all, payment in full is expected at each visit.

Annual Deductibles/Copays: Many insurance plans now have deductibles as well as a co-pay/co-insurance. If either or both apply to your coverage, they will be collected at the time of service, including the deductible and co-insurance imposed by Medicare.

Non-Covered Splints/Services: Please be aware that some of the services you receive may not be covered or considered medically necessary by Medicare or other insurers. You are responsible for payment of these products/services which may include splints, shoes, or shower bags needed after procedures.

Referrals/Authorizations: For some managed care insurance plans (such as HealthSpring, some VIVA, Tricare, and others) referrals are required by your primary care physician in order for your insurance to approve your visit with us. You are essentially responsible for making sure that referral is received. If the required referral is not received you are financially responsible for all services provided.

Missed Appointments without Sufficient Notification: All missed appointments not cancelled or rescheduled at least 24 hours in advance may be charged a $40 fee. No-show appointments place a hardship on Birmingham Podiatry as well as patients that may have needed to be seen but could not due to that appointment time being taken.

PLEASE INITIAL STATING UNDERSTANDING OF THE MISSED APPOINTMENT POLICY: _____

Patient Due Balances: You will be sent up to three statements by mail for your patient due balance, after insurance pays/denies. After the third and final notice, your account may be forwarded to our collections agency. All cost incurred including, but not limited to, reasonable collection agency fees not to exceed 30%, attorney fees, and court costs shall be your responsibility in addition to the balance due to the office for services rendered. We accept cash, check, Visa, MasterCard, and Discover.

Insufficient Funds Checks: An additional $30 will be added to your account for any returned checks. Also, we will no longer be able to accept future checks from you from that time forward.

Statement for Payment of Medicare Benefits: I request that payment of authorized Medicare benefits be made to either me or on my behalf to Dr._____ or to Birmingham Podiatry (the Supplier) for any services or items furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to Healthcare Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Statement for Payment of MEDIGAP Benefits: I request that payment of authorized MEDIGAP benefits be made either to me or on behalf to Dr._____ for any services furnished to me by the physician/supplier, I authorize any holder of medical information about me to release to (name of MEDIGAP insurer) Birmingham Podiatry any information needed to determine these benefits or the benefits payable for related services.

I have read the above policy regarding my financial responsibility to Birmingham Podiatry, PC. I understand that I am responsible for payment of deductibles, co-pays, co-insurances, and/or non-covered services, splints, or medical supplies. I authorize RELEASE OF MY MEDICAL INFORMATION to my insurance carrier and/or requesting physicians to provide continuity of care and aid in the payment of my medical claims.

Patient Signature: _____Date: _____

***Patient signature may be replaced by responsible party for the patient*

I understand that Birmingham Podiatry, PC is not a Medicaid provider. I am responsible for my primary insurance copay and deductibles. _____
***Medicaid patients only, please initial*