BIRMINGHAM PODIATRY

Date_____ Patient_____ DOB_____

Social Security #_____ Gender: (M) (F) (Other):_____ Age_____

Address_____Zip Code_____State_____

Home Phone _____Cell_____ Employer Name_____

Occupation_____Email_____ Email Permitted? (Y) (N)

Race_____ Language_____ Marital Status: (S) (M) (W) (D) (LS)

Responsible Party for patient <18 _____Number_____

Primary Care Physician_____

Date Last Seen_____
*required for some podiatric services to be billed to insurance

Pharmacy_____

Phone Number_____

Emergency Contact Information :

Name & Relationship_____

Phone Number_____

Do you have a surrogate decision maker? (Yes) (No)

Name_____

Number_____

How did you hear about us? (Internet) (Phonebook) (Friend)

Physician referral from: _____

Primary Insurance_____

Policy Holder's Name_____

Policy Holder's DOB_____

Relationship to Policy Holder: (Self) (Spouse) (Parent)

Secondary Insurance_____

Policy Holder's Name_____

Policy Holder's DOB_____

Relationship to Policy Holder: (Self) (Spouse) (Parent)

Tertiary Insurance_____

Policy Holder's Name_____

Policy Holder's DOB_____

Relationship to Policy Holder: (Self) (Spouse) (Parent)

Signature_____

CURRENT MEDICATIONS

Please List Medications even if you only know one or two. Thanks!

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PAST MEDICAL HISTORY

Please check to indicate if you have had any of the following:

____AIDS/HIV ____Ear Problems/Hearing ____Kidney Disease/Problems ____Anemia ____Epilepsy

____Neuropathy ____Heart Condition/Problems ____Fainting ____ Rash ____Gout

____Arthritis ____Swelling ____Psychiatric Care ____ Asthma ____Stroke

____ Varicose Veins ____ Back problems ____Diabetes ____Liver Disease/Problems

____Tuberculosis ____ Respiratory Disease ____Headaches/Migraines ____Bleeding Disorder

____MVP ____Sinus Problems ____Hypertension (high blood pressure)

____Hypotension (low blood pressure) ____Peripheral Vascular Disease (PVD) ____Cancer-Type: _____

*****DIABETICS, PLEASE LIST LAST A1C _____Date?_____ Last BLOOD SUGAR _____**

ALLERGIES

_____Adhesive tape _____Aspirin _____Codeine _____Seafood _____Sulfa

_____Demerol _____Iodine _____Latex _____Lortab _____Penicillin

_____Local Anesthetics _____Other:_____ _____No known allergies

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SURGICAL HISTORY

_____Appendectomy _____Gallbladder _____Hysterectomy _____Foot/Ankle _____C-Section

_____Eye _____Heart _____Thyroidectomy _____Tonsillectomy _____Back

_____Knee _____Hip _____Other:_____

**If knee or hip replacement, indicate here: (Y) _____

FAMILY MEDICAL HISTORY

Please check if anyone in your family has had the following:

__Diabetes __Heart Disease __Gout __Bleeding ulcer __Rheumatoid Arthritis __Stroke __Hypertension

__Peripheral Vascular Disease (PVD) __Cancer (Type): _____ Other:_____

SOCIAL HISTORY

Do you Smoke? (Y) (N) # per day: _____ Years: _____ Do you drink caffeine: (Y) (N) How many cups per day? _____
Do you drink Alcohol? (Y) (N)
If so, how often? (Once a month or less) (2-4 times per month) (2-3 times per week) (4 or more times per week)
Do you Exercise Regularly? (Y) (N) Do you use Recreational Drugs? (Y) (N)

PODIATRIC HISTORY

Are you here due to an injury? If so, *we need the injury date to file insurance*. INJURY DATE:_____

Shoe Size: _____Have you seen a Podiatrist before? (Y) (N) If yes, who? _____

What are you seeing us for? _____

___Achilles Tendon Pain
___Ankle Pain
___Athlete's Foot
___Back Pain
___Blister
___Bunions
___Change in skin color/Cellulitis
___Coldness in the legs/feet
___Corns/Calluses
___Difficulty walking/running
___Dry/cracked feet/heels
___**Diabetic:** Routine Foot Care
___**Diabetic:** Foot Ulcer
___Feet/Toes Numb/Tingling
___Feet/Toes/Legs Burn
___Flat Feet
___Foot/Leg Cramps
___Foot Pain
___Foot Ulcer
___Fungal Nail
___Gout
___Hammertoes
___Heel/Arch Pain
___Infected Toe/Foot
___Ingrown Nails
___Leg Pain
___Neck Pain
___Neuropathy
___Non/Poor healing sore on the leg/foot
___Pain in ball of foot/feet
___Pain in feet/legs with exercise
___Poor Coordination
___Rash
___Sweaty Feet
___Swelling foot/feet
___Tired Feet
___Toe Pain
___Wart
___Wound

TREATMENT CONSENT

I hereby give permission for the doctor and clinical staff to administer and perform agreed upon procedures, injections, and x-rays the Podiatrist deems necessary.

_____ _____

Signature of Patient, Parent, Guardian, or Representative Date

If Representative, Relationship to the patient: _____

RELEASE OF INFORMATION

Voicemail messages can be left at the following numbers with test results, appointments, etc.:

_____ _____

_____ _____

_____ _____

I give Birmingham Podiatry, PC permission to release my medical information to:

*This includes appointment information! Name must be listed to make, cancel, and inquire about appointments!

(Name and Relation)

_____ _____

_____ _____

_____ _____

NOTICE OF PRIVACY PRACTICES/ACKNOWLEDGEMENT OF RECEIPT

The Privacy Act generally requires healthcare providers to take responsible steps to limit the use, request, and disclosure of protected health information to the minimum necessary to accomplish the intended purpose of treatment, payment, healthcare operations, protection of others and disclosures required by law. This could include disclosures about notifiable diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and HIV.

I acknowledge that I have received Birmingham Podiatry's Notice of Privacy Practices.

Signature: _____ Date: _____

BIRMINGHAM PODIATRY, PC

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Birmingham Podiatry, PC and its staff to disclose my individually identifiable health information as described below. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Birmingham Podiatry, PC will use all information obtained to provide caring and quality medical care to you. As part of our standard of treatment, and pursuant to further healthcare options, we may need to share your information with a facility such as a hospital, laboratory, diagnostic service, or other healthcare provider. We may also need to share information with your insurance provider in order to expedite payment for your services provided by our practice.

Any outside entity such as an attorney, disability request, or insurance company, other than your health plan provider, will need written consent to obtain information from your file.

I understand that I may revoke this authorization at any time by notifying Birmingham Podiatry, PC in writing. If authorization is revoked it will not have any effect on any actions taken before receipt of my revocation.

Birmingham Podiatry, PC will not condition my treatment on whether I provide authorization for the requested use or disclosure.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name Relationship to Patient (If Applicable)

*** You may refuse to sign this authorization***

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*

Birmingham Podiatry

Billing Policy

February 3, 2025

1) We will bill your insurance company for services provided, however, these limitations apply:

   1. You must provide a valid insurance card with each visit. If for any reason your insurance terminates and a new card has not been provided you will receive a bill. We will only bill your new carrier if it is within time limits, outside the time limit the balance becomes patient responsibility.
   2. We will only file a secondary "Gap" plan or Medicare Supplement plan one time. If the carrier does not pay within 30 days, the balance becomes patient responsibility.
   3. We will only refile to a carrier if there is a change of information.
   4. Referrals are Patient Responsibility- failure to request a referral from your Primary Provider constitutes Self Pay and Insurance will not be filed.
   5. Copays are due at the time of Service; we do not bill copays after the fact. We require a $75.00 deposit on any office visit for patients whose plans reimburse as "Coinsurance". This deposit will apply to the visit balance and anything remaining will be refunded or applied to a future balance as requested.
   6. Deductibles and Copays will be collected in advance of any procedures, we will not schedule surgery until paid.

2) Patient Balances:

   1. Insurance carriers send an Explanation of Benefits to you when a claim is processed. Your responsibility is to review the information. If you feel there is an error in the processing, you will need to call customer service for your carrier.
   2. Patient balances are due to the Practice at the time the claim is processed. A statement will be sent the week the remittance is received from the carrier, however, if a visit falls before the statement reaches you, the balance is still due.
   3. A payment plan is available for anyone who contacts this office prior to an account being sent to collections. We do not offer payment plans to any account after it goes to collections.
   4. PAYMENT ARRANGEMENTS MUST BE MADE PRIOR TO THE VISIT, NOT AT THE TIME OF THE VISIT.
   5. Copays and balances are due at the time of the visit, the only exception will be an arrangement made before the visit. **Your account must be current to be seen.**
   6. **Your account must be current to make an appointment**, if not current, an arrangement with a down payment must be made in order to obtain an appointment.
   7. No prescriptions are written unless the account is current.

3) Medicare/Medicaid HMO

   1. This office DOES NOT take Medicaid in any form. We will submit your claim to the primary carrier which MAY OR MAY NOT pay the Medicaid portion. This portion will become the responsibility of the patient depending on how the carrier processes the claim.

I understand and agree with the payments policies as stated.

Patient Signature: _____ Date: _____