PATIENT INFORMATION

Date: _____

How did you hear about Dr. Harwood/Dr. Egly:

( ) Word of Mouth
( ) Yellow Pages
( ) Internet
( ) Sign
( ) Newspaper
( ) Dr. Referral
( ) Insurance website
( ) Southeast Podiatry website
( ) I am an Established patient
( ) Other_____

Patient's Name: _____

_____

Permanent Address: (Mailing Address)(If you are here on vacation, please provide your permanent/home mailing address)

(Address)_____

(City/State/Zip)_____

(Home Phone)_____ **(Cell Phone)** _____ **(Work Phone)** _____

_____

Guarantor / Policy Holder Information: (If a patient is a minor or another family member is the insurance policyholder/payer)

Name: _____ **Date of Birth:** _____ **SS #:** _____

(Address) _____

(City/State/Zip) _____

(Area Code + Phone) _____ **(Cell Phone)** _____

_____

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

_____

Has a physician seen you and sent you here for consultation of this condition: ____YES ____NO

Consulting Physician Name: _____ **Phone #:**_____

_____

PATIENT INFORMATION

Date of Birth: _____ **Male:** _____ **Female:** _____

Marital Status: **Married** **Divorced** **Single** **Separated** **Widowed**

Social Security #: _____

Patient Employed By: _____

Business Address: _____

Phone #: _____

Person to contact in case of emergency: _____

Phone #:_____ **Relationship:**_____

E-Mail Address _____

Race: _____

Ethnicity: Hispanic Or Not Hispanic

Preferred Language: _____

Pharmacy: _____ **City/State:** _____

PATIENT INFORMATION

Patient's Name: _____

PLEASE READ BEFORE SIGNING:

I/We the undersigned, authorize and consent to the rendering of medical treatment, including diagnostic procedures, by Southeast Podiatry, P.C. (hereinafter referred to as SPPC) physicians or authorized members of their staff, for the above patient. I acknowledge that no guarantees have been made as to the effect of such examination or treatment. Authorization is hereby given to release or obtain such information as may be necessary for the completion of my hospital/medical claims or medical care. I further agree to pay all medical expense incurred resulting from this treatment and authorization, and I assign any insurance benefits applicable. I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State. I agree, in order for SPPC to service my account or to collect monies I may owe, SPPC and / or its' agents may contact me by telephone at numbers, which could result in charges to me. I agree SPPC may also contact me by sending text messages or emails, using any email address I provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I/We have read this disclosure and agree that SPPC, its' employees and/or agents may contact me/us as described above.

I understand and agree to allow unsecure text messages to pass between the doctors of SPPC, referring doctor and to me concerning my protected health information.

I understand and agree to pay SPPC for medical services and supplies provided that are NOT PAID by my insurance, Medicare, or Medicare Advantage plans. I understand that SPPC verifies my insurance coverage as a service to me but I am solely responsible for knowing my coverage benefits. If in any case my insurance does NOT PAY for a service or supply provided; I agree to pay regardless of the insurance explanation of benefits. I agree to pay and I am requesting the service/supply regardless if my insurance, Medicare, or Medicare Advantage plan considers it, non-covered, non-allowed, non-authorized, experimental, investigational, globally included, bundled, or any other explanation they may give for not paying for a service/supply provided.

I understand and agree to pay for no show / non-cancelled / missed appointments / appointments that are cancelled or rescheduled with less than 24 hours notice $50 each occurrence. I understand that if my co-pay, deductible, or coinsurance is not paid at the time of the visit I may be billed a rebilling fee of $50 each month that I am re-billed until my balance is paid.

I understand that if my insurance company chooses to pay by credit card that I will be responsible to pay the credit card processing fee for payments made to SPPC by my insurance company.

I understand that although SPPC attempts to verify insurance coverage for patients, this is not a guarantee of benefits.

I understand that SPPC may determine deductibles and copays but does not attempt to verify insurance coverage on each diagnosis, procedure or limitation of number of procedures. I understand that my insurance may impose limitations and exclusions based on any number of reasons. I agree it is my responsibility to know my coverage and I am responsible to pay for services when my insurance does not. I understand that SPPC will provide me diagnosis codes and procedure codes to verify my coverage. If I am unsure of my coverage, treatment may need to be performed on another visit. In this scenario, I agree I would still be responsible for payment if the insurance does not pay even after they verified coverage.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Signature of Patient: _____
Print Name: _____

Signature of Legal Guardian/Guarantor/Policy Holder: _____
Print Name: _____

If Policy holder is not present

Legal Guardian Caring for a Minor/Senior

Responsible Party / Guarantor Information: (If a patient is a Minor/Senior)

Name: _____ **Date of Birth:** _____ **SS #:** _____

(Address) _____ **(City/State/Zip)** _____

(Area Code + Phone) _____ **(Cell Phone)** _____

Signature: _____

Revised 1-24-18