SOUTHEAST PODIATRY

Medicine & Surgery of the Foot

Patient Information

This information is updated yearly for office purposes.

Today's Date: _____

First Name *(required)*: _____ **Last Name** *(required)*: _____

Date of Birth *(required)***:** _____ **Male:** _____ **Female:** _____

Permanent Mailing Address *(required)***:** (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)** _____

Marital Status *(required)* ***Circle One*****: Married Divorced Single Separated Widowed**

Social Security # *(required)***:** _____

Patient Employed By: _____

Business Address: _____

Phone #: _____

Emergency Contact *(required)***:** _____

Phone #: _____ **Relationship:** _____

Reviewed 7-24-23

E-Mail Address: _____

Race: _____ **Ethnicity:** Hispanic or Not Hispanic

Preferred Language: _____

Pharmacy *(required)***: _____ City/State**: _____

Has a physician seen you and sent you here for consultation of this condition: ____ YES ____ NO

Consulting Physician Name: _____ Phone #: _____

How did you hear about Dr. Harwood ?

( ) Word of Mouth
( ) Sign
( ) Southeast Podiatry Website
( ) Other
( ) Physician Referral
( ) Internet
( ) Insurance Website
( ) I am an Established patient

Patient's Name: _____

Reviewed 7-24-23

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 expenses 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 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 doctors, healthcare providers involved in my care, 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 referral requirements, coverage benefits, copays, and deductibles. I understand and agree that I must pay these at the time of services rendered. 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 Durable Medical Equipment (hereinafter referred to as DME) are not returnable and non refundable.
- I understand and agree to pay for no show / non-cancelled / missed appointments / appointments that are canceled or rescheduled with less than 24 hours notice or notice that is not given by 5pm Friday for Monday appointments' with $65 (sixty-five dollars) each occurrence. I understand that if I am late for my appointment, I have missed my appointment and may be subject to a missed appointment fee of $65 (sixty-five dollars).
- For any payments made by check that is returned by the bank due to insufficient funds, closed account, etc…, I am responsible for a $30.00 returned check fee.
- I understand that although SPPC attempts to verify insurance coverage for patients, this is not a guarantee of benefits. I understand that my insurance plan may require a referral from my primary care physician and that it is my responsibility to obtain the referral prior to my appointment. I understand that if I fail to obtain said referral, my appointment may have to be canceled. I understand that if I do not have my copay/coinsurance/deductible amount required at the time of service, my appointment may be canceled. I understand that if my insurance company pays SPPC by virtual card payment or other card payment option, I am solely responsible for any and all processing fees incurred to SPPC as a result of that payment.
- 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. Upon request, 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 *(required)*: _____ **Date** *(required)*: _____

Print Name *(required)*: _____

Signature of Legal Guardian / Guarantor / Policy Holder (*if applicable*): _____

Print Name: _____

If Policy holder is not present, Legal Guardian Caring for a Minor/Senior <u>or</u> 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: _____ **Print Name**: _____