PATIENT INFORMATION

PLEASE PRINT CLEARLY:

PATIENT NAME:______________________________ DATE:______________

ADDRESS: ________________ CITY:________________ STATE____ ZIP:________

HOME PHONE: ____________ WORK PHONE:____________ SS #: ____________

BIRTHDATE: _____/_____/_____ AGE: ______ SEX: M / F MARITAL STATUS: M/ S /D/ W

EMPLOYER: ______________________ OCCUPATION:____________________

ADDRESS: ______________________ CITY:____________ STATE: _____ ZIP:________

EMERGENCY CONTACT:______________________ RELATIONSHIP:______________

FAMILY PHYSICIAN:__________________________ PHONE: ______________

REFERRED BY: ____

PLEASE BE SPECIFIC IN ANSWERING THE FOLLOWING QUESTIONS

WHAT IS YOUR FOOT PROBLEM?

WHEN DID THIS PROBLEM START?

HAVE YOU HAD FOOT TREATMENT BEFORE? BY WHOM?

PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING:

PATIENT'S MEDICAL STATUS

YES	NO		YES	NO	
☐	☐	DIABETES	☐	☐	DRUG REACTIONS
☐	☐	HIGH BLOOD PRESSURE	☐	☐	ASTHMA
☐	☐	HEART DISEASE	☐	☐	ANEMIA
☐	☐	ARTHRITIS	☐	☐	HAY FEVER

ALLERGIES

YES	NO		YES	NO	
☐	☐	PENICILLIN	☐	☐	ADHESIVE TAPE
☐	☐	ASPIRIN	☐	☐	LOCAL ANESTHETIC
☐	☐	CODINE	☐	☐	OTHER: __________

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ASSIGNMENT OF BENEFITS:

I HEREBY ASSIGN PAYMENT OF AUTHORIZED MEDICARE AND/OR ANY OTHER MEDICAL/SURGICAL BENEFITS, TO INCLUDE WORKMENS COMPENSATION OR AUTO ACCIDENT BENEFITS TO WHICH I AM ENTITLED, TO BE MADE PAYABLE TO STEVEN R. BINDER, D.P.M. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL.

ALTHOUGH I HAVE REQUESTED THE DOCTOR TO BILL MY INSURANCE COMPANY ON MY BEHALF, I CLEARLY UNDERSTAND THAT IT IS STILL MY RESPONSIBILITY TO MAKE SURE THE BILL IS PAID IN A REASONABLE TIME. IF FOR ANY REASON ANY PORTION OF MY BILL IS NOT PAID BY MY INSURANCE, I FURTHER AGREE TO MAKE ARRANGEMENTS FOR PROMPT PAYMENT OF THE BILL.

SIGNATURE: X______________________________________ DATED:______________

WITNESS: ____ DATED:______________

Patient's Name: Ins. Name:

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

In the event, that the Insurance Company fails to pay for certain items or services, it is the patient's responsibility to know your policy and what it covers. Such as:

1) **Deductible's (In or Out-of-Network)**
2) **Copay's**
3) **Non covered Benefits**

Our doctor participates with many different Insurance Policies & Plan's. It is the patient's responsibility to know if the doctor participates with your individual plan.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself.

By signing below I am aware I may be billed for services not normally covered by my Insurance Plan.

_______________________ X_______________________

Date **Signature of patient or person acting on patient's behalf**

NOTE: Your health information will be kept confidential. Any information that we collect about you will be kept confidential in our offices.

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

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.

____ ______________________

Patient Name (please print) Date

____

Parent or Authorized Representative (if applicable)

X______________________________________

Signature