PATIENT INFORMATION

Patient's Name_____ Phone #_____

Address_____
Street City State Zip Code

Date of Birth_____ /_____ /_____ Age_____ Sex: _____M _____F

Employer_____ Occupation _____

Emergency Contact_____
Name Phone Number

Email _____ How did you hear about our office? _____

Primary Physician_____
Name Address City State Phone Number

Pharmacy _____
Name Address City State Phone Number

PRIMARY INSURED

___Self (if self, you do not need to complete the rest of this section) ___ Spouse ____Parent _____ Other_____

Name_____ Phone #_____

Address_____
Street City State Zip Code

Social Security #_____ Date of Birth_____ /_____ /_____ Age_____ Sex: ___M ___F

INSURANCE

Primary Insurance Company Name: _____

Secondary Insurance Company Name: _____

_____
Patient/ Guardian Signature **Date**

(01/2025)

PATIENT MEDICAL INFORMATION

What condition are you being seen for today? _____
_____

Height: _____ **Weight**: _____ **Shoe Size:** _____

List Prescription Medications Currently Taking: (Attach list if additional space needed)

NAME OF MEDICATION	DOSE	REASON FOR TAKING
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any Medication and Food Allergies: ____ NO KNOWN ALLERGIES

Name of Medication	Reaction
_____	_____
_____	_____

Please **circle** any of the following conditions that you currently have or have had:

Acid reflux/GERD	Anemia	Arthritis	Asthma
Bleeding disorders	Cancer	Cataracts/ Glaucoma	Circulatory Condition
Diabetes	Gout	Heart disease	Hepatitis
High Blood Pressure	High Cholesterol	HIV+	Kidney stones
Liver Disease	Respiratory Issues	Seizures/Epilepsy	Stroke
Thyroid disease	Other: _____		

List any surgeries: _____

Do you use tobacco? Yes ___ No ___
Do you use alcohol? Yes ___ No ___
Occupation _____

Please check if there is a family history of:

	Father	Mother	Brother	Sister
Cancer	_____	_____	_____	_____
Circulation issues	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Heart conditions	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____

Other_____

FINANCIAL AGREEMENT

We are committed to providing you with the best possible podiatric care. To help us achieve this goal, we need your assistance and understanding of our payment policy.

The amount of benefits you are entitled to will depend solely on what your specific insurance company offers to its members. Your co-pay is required at the time of your visit. Some insurance plans cover as little as 30% and some as much as 100% of your medical care, with most falling in the 50-80% range. **Almost all plans (including PPO's and Medicare) exclude certain services that you may not be aware of. Our staff recognizes this and will attempt to take the time to discuss charges with you prior to a service if we know your insurance will not cover it.**

Some plans base the amount of benefits on a chart or schedule of fees arbitrarily developed by the insurance carrier. The actual amount paid by your plan is 80% of the fee made up by the insurance company, not the actual fee charged by our office. Our fees are generally considered to fall within the acceptable range of most carriers and therefore most procedures are covered up to the maximum allowance determined by each carrier. This applies only to those companies who pay a percentage (30, 50, or 80%) of the U.C.R.; which is defined as usual, customary and reasonable fees for this region.

The type of treatment you receive is **NOT** based on the type of insurance plan you have. It is not in the best interest of the patient to compromise quality care in order to satisfy an insurance company's fee schedule. If you are a member of an insurance company that we are affiliated with, we will file the claim directly with the insurance company, minus the portion you, the insured, are responsible for. We will then bill you if there is a balance remaining after the carrier has paid, or will reimburse you if the carrier pays more than expected. **All unpaid balances are subject to a 1.5% service charge per month, and collection costs of 35% for outstanding balances forwarded to our external collection agency.**

If you are a member of a plan that we are not affiliated with, we ask that you pay the full amount of your visit, at the time of your visit. Our office staff will be happy to provide you a copy of your bill, which has the nationally accepted diagnosis and treatment codes necessary for your insurance company to process your claim. We gladly accept the following payment methods: Cash, Check, MasterCard, and Visa. **Returned checks are subject to a $35.00 processing fee.**

If your benefit plan required a pre-certification or pre-authorization, we will submit a treatment plan for review by your carrier. Please be aware that, per your insurance carrier, pre-authorization does not guarantee payment.

Your insurance company is expected to either pay or deny the claim within 60 days. We will do everything we can to expedite your claim. Should the insurance company delay payment, you will ultimately become responsible for the payment of the medical services you received and in turn your insurance carrier will be responsible to you. We realize that temporary financial problems may affect your ability to pay your medical bill in full. If such problems arise, please contact our office at once and we will work out a payment plan agreeable to both of us.

If your insurance required physician referrals, it is your responsibility to obtain them. If you do not have a valid referral at the time of your office visit, you will be responsible for all charges incurred. Do not depend on your office staff to keep track of your referrals for you. If you have any questions about this agreement or are uncertain regarding your insurance coverage, we will answer your questions as best we can; we are here to help you. Your insurance company may also be helpful in answering more specific questions regarding your plan.

_____ _____

Patient/ Guardian Signature **Date**

(01/2025)

RELEASE AND ASSIGNMENT OF BENEFITS

I authorize payment of the medical and surgical benefits directly to Orlando Podiatry Center and to release information including the diagnosis and the records of any such medical or surgical care. I am also giving Orlando Podiatry Center all rights to inquire on my behalf on any medical reviews relating to my medical benefits, whether assigned or non-assigned claims.

I acknowledge that I may receive durable medical equipment, and various other types of medical supplies. I understand that these items cannot be returned to the office; however, they may be adjusted or corrected as deemed medically necessary. I also understand that the use of these items is not a guarantee for treatment or healing.

_____ _____

Patient/ Guardian Signature **Date**

OFFICE FEES

WE IMPOSE A SURCHARGE OF 3.9% ON CREDIT CARDS,
which is not greater than our cost of acceptance.

Completion of Forms:
I acknowledge I will be charged a $40 fee for EACH form to be completed by the physician.
Example: FMLA, Short-Term Disability, ect.

Medical Records:
I acknowledge I will be charged $1 per page for the first 25 pages and $0.25 for each additional page for my medical records. There will be no charge if records are faxed to another medical office.

Missed Office Visit:
I acknowledge I will be charged a $65 fee should I not show and/or do not cancel my appointment at least 24 hours in advance.

X-rays:
I acknowledge I will be charged a $15 fee for copies of my x-rays on a CD.

_____ _____

Patient/ Guardian Signature **Date**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
-Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
-Obtain payment from third party payers (insurance companies)
-Conduct normal healthcare operations such as quality assessments and physician certifications
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/ Guardian Signature **Date**