Eastern Shore Family Foot Care
Putting your foot first

PATIENT INFORMATION

Today's Date: _____

PATIENTS NAME (PLEASE PRINT):_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ SEX (M or F):_____

RACE: _____ ETHNICITY: _____

HOME PHONE: _____ CELL PHONE: _____

E-MAIL ADDRESS: _____

IF WE NEED TO CONTACT YOU, PLEASE LET US KNOW IF WE MAY:

LEAVE A DETAILED MESSAGE ***OR*** MESSAGE TO CALL BACK: _____

BEST # TO CONTACT YOU: _____

HOW WOULD YOU LIKE TO RECEIVE YOUR APPOINTMENT REMINDER: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ CELL PHONE: _____

FINANCIAL RESPONSIBILITY

****IS PATIENT A DEPENDENT? YES NO (CIRCLE ONE)

IF SO, PLEASE PROVIDE INFORMATION FOR PERSON WHO IS FINANCIALY RESPONSIBLE:

POLICY HOLDER NAME: _____

ADDRESS: _____

POLICY HOLDER PHONE #: _____

POLICY HOLDER DOB: _____

Consent to Treat Form

1. I _____ (patient name) give permission for **Eastern Shore Family Footcare** to give me medical treatment.

2. I allow **Eastern Shore Family Footcare** to file for insurance benefits to pay for the care I receive.

   I understand that:
   - **Eastern Shore Family Footcare** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature Date
(for children under 18)

_____ _____

Print name

BENEFIT ASSIGNMENT AUTHORIZATION

I, _____, UNDERSTAND THAT SERVICES RENDERED TO ME BY **EASTERN SHORE FAMILY FOOTCARE** ARE MY FINANCIAL RESPONSIBILITY AND THAT THE PROVIDER WILL BILL MY INSURANCE COMPANY AS A COURTESY. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY BENEFITS DIRCTLY TO **EASTERN SHORE FAMILY FOOTCARE** AND I UNDERSTAND THAT I WILL BE FULLY RESPONSIBLE FOR ANY OUTSTANDING BALANCE ON MY ACCOUNT. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** THIS PAYMENT WILL NOT EXCEED MY INDEBTEDNESS TO THE ABOVE-MENTIONEED ASSIGNEE AND I HAVE AGREED TO PAY, IN A CURRENT MANNER, ANY BALANCE OF SAID PROFESSIONAL SERVICE CHARGES OVER AND ABOVE THIS INSURANCE PAYMENT.

I HAVE BEEN GIVEN THE OPPORTUNITY TO PAY MY ESTIMATED DEDUCTIBLE AND CO-INSURANCE AT THE TIME OF SERVICE. I HAVE CHOSEN TO ASSIGN THE BENEFITS, KNOWING THAT THE CLAIM MUST BE PAID WITHIN ALL STATE OR FEDERAL PROMPT PAYMENT GUIDELINES. I WILL PROVIDE ALL RELEVANT AND ACCURATE INFORMATION TO FACILITATE THE PROMPT PAYMENT OF THE CLAIM BY MY INSURANCE COMPANY.

I ALSO UNDERSTAND THAT SHOULD MY INSURANCE COMPANY SEND PAYMENT TO ME; I WILL FORWARD THE PAYMENT TO **EASTERN SHORE FAMILY FOOTCARE** WITHIN 48 HOURS. I AGREE THAT IF I FAIL TO SEND THE PAYMENT TO THE PROVIDER AND THEY ARE FORCED TO PROCEED WITH COLLECTIONS PROCESS; I WILL BE RESPONSIBLE FOR ANY COST INCURRED BY THE OFFICE TO RETRIEVE THEIR MONIES. IN THE EVENT PATIENT RECEIVES ANY CHECK, DRAFT OR OTHER PAYMENT SUBJECT TO THIS AGREEMENT, I WILL IMMEDIATEDLY DELIVER SAID CHECK, DRAFT OR PAYMENT TO PROVIDER. ANY VIOLATION OF THIS AGREEMENT WILL, AT PROVIDER'S ELECTION, TERMINATE PATIENT CHARGE PRIVILEGES WITH PROVIDER AND BRING ANY BALANCE OWED BY PATIENT TO PROVIDER IMMEDIATELY DUE AND PAYABLE.

I AUTHORIZE THE PROVIDER TO INITIATE A COMPAINT OR FILE APPEAL TO THE INSURANCE COMMISSIONER OR ANY PAYER AUTHORITY FOR ANY REASON ON MY BEHALF AND I WILL PERSONALLY BE ACTIVE IN THE RESOLUTION OF CLAIMS DELAY OR UNJUSTIFIED REDUCTIONS OR DENIALS.

I UNDERSTAND ALL ACCOUNTS NOT PAID AFTER SIXTY (60) DAYS WILL INCUR A CHARGE OF 1.5% PER MONTH, (18% PER YEAR) COMPOUNDED MONTHLY ON THE UNPAID BALANCE. ALL ACCOUNTS OVERDUE AFTER SIXTY (60) DAYS MAY BE TURNED OVER TO A THIRD PARTY FOR COLLECTION AND COURT ACTION. THE ACKNOWLEDGER AGREES THAT THEY WILL BE LIABLE FOR, AND PAY ALL COSTS OF COLLECTION, INCLUDING, BUT NOT LIMITED TO: FACTOR'S FEES, ATTORNEY'S FEES, COURT COSTS AND SERVICE FEES, COST OF SKIP TRACE AND INVESTIGATION, ASSET SEARCHES, ADDRESS VERIFICATIONS, BANKRUPTCY SEARCHES, MILITARY SERVICE CERTIFICATION, EMPLOYMENT SEARCHES, GARNISHMENT LIENS AND ATTACHMENTS AS MAY BE REQUIRED TO COLLECT AND RECOVER ANY UNPAID AMOUNT.

I ALSO UNDERSTAND ALL RETURNED CHECKS WILL BE SUBJECT TO THE GREATER OF DOUBLE THE AMOUNT OF THE CHECK OF FORTY DOLLARS, OR BE SENT TO THIRD PARTY FOR RECOVERY AT WRITER'S EXPENSE.

THE UNDERSIGNED AGREES THAT BY THE SIGNATURE BELOW THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND CONDITIONS AND I AGREE TO BE BOUND THEREBY.

SIGNATURE DATE

HIPAA RELEASE AND NOTICE OF PRIVACY PRACTICES

EASTERN SHORE FAMILY FOOTCARE may disclose protected health information(PHI) about me and the treatment I am receiving, including copies of my medical record, to: (1) my insurance carrier, (2) any person or firm which conducts reviews of my treatment on behalf of my insurance company, and (3) the peer review organization designated by the appropriate governmental bodies to review physician utilization under the Medicare program. The information will be used by these parties to determine the medical necessity of the services I am receiving, to improve the quality of services provided, and to process payment for all or part of my physician bill. This authorization applies to all visits to this practice site and all other services provided by EASTERN SHORE FAMILY FOOTCARE associated with those visits.

EASTERN SHORE FAMILY FOOTCARE is required by federal law to maintain the privacy of heath information that is protected by law, and to provide you with notice of our legal duties and privacy practices with respect to your protected health care information. Our "Notice of Privacy Practices" is available in the office for your review. I understand that the "Notice of Privacy Practices" is available upon request.

By signing below, I agree that I have read, understand and agree with this contract.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____ _____

Print Patient Name **Date of Birth**

_____

****Print Name of Legal Guardian or Power of Attorney, if applicable**

****PLEASE NOTE IF YOU HAVE POWER OF ATTORNEY (POA), WE REQUIRE A COPY OF THIS DOCUMENTATION FOR OUR RECORDS.**

RELEASE OF INFORMATION

PLEASE LIST NAME, RELATIONSHIP AND PHONE # OF THOSE PEOPLE WE CAN RELEASE INFORMATION TO:

_____

_____

_____

MEDICAL INFORMATION

PRIMARY CARE PROVIDOR: _____

LAST SEEN: _____ DID HE/SHE REFER YOU? _____

PHARMACY OF CHOICE: _____

LOCATION: _____

STATE IN YOUR OWN WORDS YOUR MEDICAL REASONS FOR VISITING OUR OFFICE TODAY:

_____

_____

_____

IF APPLICABLE; WHEN DID INJURY/PAIN FIRST OCCUR: _____

WERE X-RAYS DONE: _____ ***IF*** X-RAYS WERE DONE; WHEN:_____

WHERE: _____

KNOWN DRUG ALLERGIES: _____

_____

PLEASE LIST ALL MEDICATIONS ***OR*** PROVIDE A LIST: _____

_____

_____

MEDICAL HISTORY: ****PLEASE CHECK ALL BOXES THAT APPLY TO PATIENT****

☐ Anemia	☐ Anxiety	☐ Arthritis	☐ Asthma	☐ BPH	☐ Back Problem
☐ Breast Ca	☐ CAD	☐ CHF	☐ COPD	☐ Cancer	☐ Cholesterol High
☐ Dementia	☐ Depression	☐ Dermatitis	☐ DIABETES	☐ Epilepsy	☐ GERD
☐ Glaucoma	☐ Gout	☐ HIV	☐ Headache	☐ Hepatitis	☐ Hypertension
☐ MI	☐ Migraine	☐ Pneumonia	☐ Renal stone	☐ Stroke	☐ TB
☐ Thyroid Dz	☐ Ulcer (GI)	☐ Other: _____			

_____

PLEASE LIST PAST SURGERIES:

_____

_____

_____

HOW TALL ARE YOU? _____ HOW MUCH DO YOU WEIGH? _____

ARE YOU A CURRENT SMOKER? _____ HAVE YOU EVER SMOKED? _____

DO YOU DRINK ALCOHOL? _____ ***IF*** YES, HOW OFTEN? _____

HAVE YOU RECEIVED A FLU SHOT? _____

HAVE YOU RECEIVED A COVID SHOT? _____

IF OVER 65, HAVE YOU RECEIVED YOUR PNEUMONIA SHOT? _____

PLEASE LIST ANY PERTINENT FAMILY HISTORY:

_____

_____

_____

_____

_____

_____