PODIATRIC REGISTRATION FORM

PATIENT INFORMATION

Name:		
Address:	Home Phone #:	Date:
City:	State:	Zip:
Sex:	SS#:	Birth Date:
Marital Status:	Work Phone Number:	
Occupation:	Spouse's Name:	
Employer:	Spouse's Occupation:	
Employer ‘s Address:	Spouse’s Employer:	
Whom may we thank for referring you?		

MEDICAL CONTACT INFORMATION

Contact in Case of Emergency:	Phone Number:
Family Physician:	Phone Number:
Physician Address:	Date of Last Visit:
Primary Pharmacy:	Street/City:

INSURANCE

Person Responsible for this Account:	
Relationship to Patient:	
Primary Insurance Co.:	
Subscriber’s Name:	SS#:
Relationship to Patient:	Birth Date:
Secondary Insurance Co.:	
Subscriber’s Name:	SS#:
Relationship to Patient:	Birth Date:

ASSIGNMENT AND RELEASE:

I, the undersigned certify that I (or my dependent) have coverage with the above Insurance Company and assign directly to John E. Bubser, D.P.M. all Insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize use of this signature on all insurance submissions.

Responsible Party : _____ **Date:** _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to John E. Bubser, D.P.M. for any service furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA-1500 form, or elsewhere on another approved claim form or electronically submitted claim, my signature authorizes the release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and I am responsible only for deductible, coinsurance and non covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Responsible Party : _____ **Date:** _____

PODIATRIC REGISTRATION FORM—CONTINUED

What is the reason you are seeing the doctor today? _____

MEDICAL HISTORY: Circle "Yes" or "No" for each problem you have now or have had in the past.

AIDS/HIV	Yes	No	Ear Problems	Yes	No	Stroke	Yes	No
Anemia	Yes	No	Epilepsy	Yes	No	Thyroid Disease	Yes	No
Angina	Yes	No	Eye Problems	Yes	No	Respiratory Disease	Yes	No
Arthritis	Yes	No	Foot or Leg Cramps	Yes	No	Rheumatic Fever	Yes	No
Artificial Heart Valve	Yes	No	Gout	Yes	No	Shortness of Breath	Yes	No
Artificial Joints	Yes	No	Heart Attack	Yes	No	Sickle Cell Disease/Trait	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No	Sinus Problems	Yes	No
Back Problems	Yes	No	Hepatitis or Jaundice	Yes	No	Smoker	Yes	No
Bleeding Disorders	Yes	No	High Blood Pressure	Yes	No	Special Diet	Yes	No
Cancer	Yes	No	Kidney Problems	Yes	No	Stomach Ulcer	Yes	No
Chemical Dependency	Yes	No	Liver Disease	Yes	No	Swelling in Ankles or Feet	Yes	No
Chronic Diarrhea	Yes	No	Low Blood Pressure	Yes	No	Swollen Neck Glands	Yes	No
Chronic Headache	Yes	No	Lyme Disease	Yes	No	Tuberculosis	Yes	No
Circulation Problems	Yes	No	Nervous Problems	Yes	No	Unexplained Weight Loss	Yes	No
Currently Pregnant	Yes	No	Phlebitis	Yes	No	Varicose Veins	Yes	No
Diabetes	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No

CURRENT MEDICATIONS: List all medications you are currently taking:

Prescriptions	Prescriptions	Prescriptions

ALLERGIES: Check any allergies that you have now or have had in the past:

ALLERGY CAUSE		
Adhesive Tape		
Aspirin		
Codeine		
Iodine		
Latex		
Local Anesthetics		
Penicillin		
Sulfa Drugs		

SURGICAL HISTORY: List all surgeries you have had and the date you had them:

SURGERY:	DATE:	SURGERY:	DATE:

HOSPITAL IN-PATIENT HISTORY: List hospitalizations dates and other than for surgery above:

REASON HOSPITALIZED	Date

CONSENT & ACKNOWLEDGEMENT

I certify that the information on this form is true and correct to the best of my knowledge. I give my permission to the physician to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and ankles.

Patient's Signature _____ **Date:** _____

Parent's or Guardian's Signature _____ **Date:** _____

I acknowledge that I printed the HIPAA form, (Health Insurance Portability & Accountability Act) with the Patient Registration form and I had the opportunity to read and understand the form.

Patient's Signature _____ **Date** _____

Parent's or Guardian's Signature _____ **Date:** _____

New Patient Health History Form

Patient:_____ **Date of Birth:**_____ **Date:**_____

Email:_____@_____

Primary Language: ___English ___Spanish ___Other

Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino

Race: ___American Indian or Alaskan Native ___Asian ___White

___Black or African American ___Native Hawaiian or Pacific Islander

___Other_____

Smoking Status: ___ Current Smoker Everyday ___Heavy Tobacco Smoker

___ Light Tobacco Smoker ___Former Smoker ___ Never A Smoker

Are you a Tobacco User? (other than cigarettes) ___Yes ___No *examples: chewing tobacco, cigars, pipe

Family History: (Please list any past family medical history especially any diabetes, high blood pressure, heart disease, other)

___ Mother ___ Father ___ Sister ___ Brother _____

___ Mother ___ Father ___ Sister ___ Brother _____

___ Mother ___ Father ___ Sister ___ Brother _____

Financial Policy of John E. Bubser D.P.M., P.A.,
Prince George's Multi-Specialty Surgery Centre, Inc.

Thank you for choosing John E. Bubser, D.P.M., P.A. for your foot care provider. We are committed to providing excellent health care services to you, our patient. In order to reduce confusion and misunderstanding between patients and the staff, John E. Bubser D.P.M., P.A. has adopted the following financial policy. If you have any questions about the policy, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your understanding of your financial responsibilities as an essential element of your care and treatment.

INSURANCE. We participate with most insurance plans, including Medicare. If you are not insured by a plan to which we participate, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. If your insurance changes please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

CO-PAYMENTS AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time off service. ***This arrangement is part of your contract with your insurance company.*** We are required to collect co-payments and deductibles from patients. Please help us in upholding the law by paying your co-payment at each visit. We will estimate the amount you owe based on information we received from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim-regardless of our estimation.

NON COVERED SERVICES. Please be aware that some- and perhaps all- of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. Certain procedures such as x-rays and/or ultrasounds are necessary for the evaluation or management of your condition. These procedures may or may not be covered under your office visit co-pay. Some insurance companies apply these charges toward your deductible. You will be responsible for these additional charges.

PROOF OF INSURANCE. All patients must complete our new patient Registration forms before seeing the doctor. We must obtain a copy of your driver's license, current valid insurance card and referral if needed. We may accept assignment of insurance following verification of your coverage. If you fail to provide us with the correct insurance information, you may be responsible for the balance of a claim.

CLAIMS SUBMISSION. As a courtesy, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. ***Your insurance benefit is a contract between you and your insurance company***.

 _____ Initials

REFERRALS. It is the patient's responsibility to ensure the office receives required referrals prior to your appointment, if your insurance company mandates. Failure to do so may result in your appointment being cancelled or rescheduled and you will be responsible for any charges incurred.

BILLING INFORMATION AND COVERAGE CHANGES. *You must provide your most current billing* address, telephone numbers including cell, work and home, any other important contact information. If your address or contact information changes, it is *your* responsibility to contact us with the updated information. We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If your insurance changes, please notify us before your next visit and we will make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 30 days, the balance will automatically be billed to you.

NONPAYMENT. Payment in full is due upon receipt of the statement. For your convenience we accept cash, personal checks, debit and credit cards. If the bank returns the check unpaid for any reason, we will add $25.00 to your original balance.

Patients balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts may be referred to a professional collection agency and/or attorney for further collection activity.** If your account is turned over to collections, not only will you be responsible for full payment of the balance of your account, an additional 30% of your balance will be added to your bill in order to settle the collection agency fee.

RETURNED CHECKS. There is a fee of $25.00 for all Returned checks.

MISSED APPOINTMENTS. Unless cancelled at least 24 hours in advance, our policy is to charge a $30 No Show Fee for missed or late-cancelled appointments.

RESCHEDULING/CANCELLED SURGERY. There will be a $50 charge each time a surgery is rescheduled. Any surgery cancellation made within 7 days of scheduled surgery will be subject to a fee of $250. These charges are **not** covered by insurance. Please help us serve you better by keeping scheduled appointments.

SURGERY FEES. We require payment of your deductible, co-payment, and co-insurance day of pre-op appointment. For procedures that are not covered by insurance and for patients who do not have medical insurance, we require full payment (100%) day of pre-op appointment. Confirm if prior authorization may be required by your insurance company.

Orthotics. Orthotics is a non-covered service by some insurance plans. Please check with your insurance company prior to the examination and casting for orthotics to determine your benefit. A deposit of $175.00 is required at the time of casting.

Minors. The child's parent or guardian is responsible for payment at time of services. For unaccompanied minors non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the treatment and charges.

ARRIVING LATE. If you are not checked in at the front desk 5 minutes before your scheduled appointment time, we reserve the right to re-schedule your appointment.

MEDICAL RECORDS REQUESTS. The patient or guardian will need to complete and sign a Release Form before medical records can be copied and released to you. A $20 per person payment for medical records charged to cover the cost of our supplies, labor and time. The fee for copying x-rays onto a CD is $5.00. There is no cost to you if we are simply faxing or emailing your records to another provider. In all the above situations, please allow 2 weeks for requested transfers or copying of your medical record.

MEDICARE. John E. Bubser D.P.M. P.A. is a participating Medicare provider and will file claims for Medicare beneficiaries. Any deductibles, co-insurance services are the responsibility of the patient. If there is a supplemental coverage available, we will file a claim to the second carrier as a courtesy. However, follow –up with the supplemental carrier, as well as amounts not paid, are the responsibility of the patient. Medicare does not always cover all services. There are certain types of routine care, as stated in the Medicare benefits, which may not be covered.

Medicare pays 80% of their "allowed" amount and you will be responsible for the remaining 20% if you do not have secondary insurance. ***It is important to keep mind that not all secondary/supplemental insurance plans will cover the full 20% balance or the Medicare Annual Deductible.*** You will be financially responsible for any amount your secondary/supplemental plan does not pay, whether in full or in part, such as the deductible and/or co-pays.

COPIES AND FORMS. Copies of your medical record will be provided directly to you at a cost of 75 cents a page (non-x-ray). Forms or letters to be completed by the physician (i.e. disability, etc.) are subject to a $20.00 charge. Please allow 10 business days for completion of forms.

ADDITIONAL CHARGES.

Patients may also incur, and are responsible for the payment of additional charges. These charges may include, but are not limited to:

1. A $25.00 charge for returned checks
2. A $30.00 charge for routinely missed appointments without 24 hours advance notice
3. A charge for extensive phone consultations
4. A $20.00 charge for copying patient records, plus $0.75 per page after the first 19 pages.
5. A $5.00 charge for copying patient X-Rays on to a computer disk.
6. A $45.00 charge for completion of extensive forms brought in by the patient.
7. A $50 charge rescheduling surgery.
8. A $250 charge if surgery is cancelled within 7 days of scheduled surgery.

REMINDER CALLS. A courtesy Reminder call is a call reminding you of your appointment. After hearing the message, it is unnecessary to call the office to confirm your appointment. If you need to cancel or reschedule your appointment, you must call the office.

 _____ Initials

Assignment and Release. I hereby authorize my insurance benefits to be paid directly to the physician. I am legally responsible for any amount which is not paid by my insurance even if my physician is participating with my insurance company. I also authorize the physician to release any information required to process the claim. I understand that accounts are considered past due if no payment is received within 30 days of billing. If payment is not made within that time or services rendered, **I agree to pay any and all necessary cost of collections, including but not limited to the collection's fee of 30% on the balance outstanding, and service process fees.**

PRINT Patient Name: _____

My signature below is my acceptance of this agreement.

Signature: _____ Date: _____

GUARANTOR/FINANCIALLY RESPONSIBLE PARTY (IF DIFFERENT THAN ABOVE)

PRINT NAME: _____

GUARANTOR ADDRESS: _____CITY: _____

STATE: _____ ZIP CODE: _____ GUARANTOR PHONE# _____

RELATIONSHIP TO PATIENT: _____

GUARANTOR SIGNATURE: _____ DATE: _____

John E. Bubser D.P.M., P.A.

Authorization for the Sharing of Protected Health Information

Name:_____ DOB:_____

Home Phone Number:_____

The providers/staff of John E. Bubser D.P.M., P.A.
may discuss my medical condition and/or history with:

_____

NAME	RELATIONSHIP
_____	_____
_____	_____

If I <u>DO NOT WANT</u> certain information about me disclosed, I will list it below:

_____

_____

_____

_____

_____ _____

Patient Signature Relationship Date
(Parent/Legal Guardian or Appropriate Consenting Party)

EXPIRATION: This authorization expires no later than one year from the date it was signed.

THIS CONSENT MUST BE MAINTAINED FOR 6 YEARS

INITIAL OF PERSON TAKING REQUEST:_____