BROWN FOOT CARE CENTER, PC

204 Pickens Street Eutaw, Al 35462 205-372-0708	819 Mimosa Park Road Tuscaloosa, AL 35405 205-752-7503	1355 Hwy 80 West Demopolis, AL 36732 334-289-4445

DATE: _____

Patient Name: _____ Home Number: (____)_____

Gender: _____ Social Security #: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Cell Phone Number: _____ E-Mail: _____

Employer: _____ Work Phone Number: _____

Insurer's (Responsible party) Name: _____ Date of Birth: _____

Phone Number: _____ Social Security #: _____

Relationship to Patient: _____ How did you hear about us? _____

In case of Emergency, please call: _____

- By providing my email address, I consent to participation in the patient portal program. This program allows online access to certain parts of your electronic medical records. A secure message with your login information will be generated to you. Follow the link for instructions on how to access your portal.
- I hereby consent to receive text messages about upcoming appointments.
- You further give Brown Foot Care Center permission to access any database available to collect and update my medication list.
- I hereby authorize the physician to furnish information to insurance carriers concerning my health condition and irrevocably assign to the Brown Foot Care Center all benefits and payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as valid as the original.
- My signature below implies agreement and consent of the above unless otherwise stated.

_____ _____

Patient Signature Date

BROWN FOOT CARE CENTER - OFFICE FINANICAL POLICIES

We ask that you please turn off your cell phone or at the very least place it on silent mode as a courtesy to other patients. Please do not answer your cell phone in the treatment room, thank you in advance.

1. A copy of the patient's insurance card is required on EACH AND EVERY visit to us. It is the patient's responsibility to make sure that the information provided to our office is accurate and current. Failure to provide such information will result in YOUR responsibility for all services.
2. Referrals/authorizations. It is your responsibility to list a primary care physician, if your insurance requires one. It is your responsibility to contact your primary physician prior to the visit in our office and obtain a referral, if your plan requires one. If no referral is on file for that date of service, you will be responsible for full payment or reschedule until one is obtained.
3. We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do 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. Knowing your insurance benefits is your responsibility.
4. Co-payments and deductibles for participating insurances are due at the time of service. (Our contract with your insurance company states that we MUST collect copayments every time a patient presents to the office.) If you disagree or have questions about this policy, please contact your insurance company for verification. We may ask that non-emergency appointments be rescheduled if copayments are not paid.
5. Medicare: We are a participating Medicare provider. However that does not mean that all services are covered. Patients are responsible for paying the annual deductible if it has not been met yet and the 20% copayment of allowed amount for an item or service.
6. Secondary insurance medical claims will be forwarded for consideration if you have one after receiving an explanation of benefits (EOB) from your primary insurance, except for Medicaid. (Medicaid does not pay for Podiatry in the state of Alabama)
7. All forms for FMLA, disability or other reasons will be filled out within 48 hours and faxed/mailed to the number/address provided a maximum of two times. If they do not receive it, then it will become your responsibility to provide the information to them. Letters written on your behalf will incur a $50 charge and payment is due prior to sending out.
8. You will be sent **three (3)** notices of your financial responsibility. After the third and final notice, your account may be forwarded to collections. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office. If you have difficulties in resolving your account, then please contact the office so payment arrangements can be made.
9. Thirty ($30) will be added to your account if a check is returned for insufficient funds, plus be sent to an agency for collection which may incur additional fees on their end.

I have read the above office policies. I understand that I am financially responsible for co-payments and other charges not covered by any insurance.

_____ _____

Patient Signature Date

Patient Acct# _____

PATIENT MEDICAL HISTORY

Patient History as _____/_____/_____

PATIENT NAME:_____ SOC. SEC. NO.: _____

SHOE SIZE:_____ WEIGHT: _____ HEIGHT:_____

HAVE YOU EVER BEEN TREATED FOR:

_____ AIDS/HIV
_____ Anemia
_____ Arthritis
_____ Asthma
_____ Bleeding Disorder
_____ Blood Clot
_____ Cancer
_____ Depression/Psychiatric Disorder
_____ Diabetes
_____ Fibromyalgia
_____ Gout
_____ Headaches
_____ Heart Disease
_____ Hepatitis
_____ High Cholesterol
_____ Hypertension
_____ Kidney Disease
_____ Liver Disease
_____ Lung Disease
_____ Mitral Valve Prolapse
_____ Organ Transplant
_____ Osteoporosis
_____ Peripheral Vascular Disease
_____ Rheumatoid Arthritis
_____ Seizures/Epilepsy
_____ Stroke
_____ Substance Abuse
_____ Thyroid Problems
_____ Tuberculosis
_____ Varicose Veins

ARE YOU CURRENTLY PREGNANT? YES NO HAVE YOU EVER HAD SURGERY? YES NO _____

_____

_____

DO YOU SMOKE? YES NO HAVE YOU EVER SMOKED? YES NO PACKS A DAY _____YEARS _____

IF YOU QUIT, WHEN DID YOU DO SO?_____

DO YOU DRINK ALCOHOLIC BEVERAGES? YES NO DO YOU TAKE RECREATIONAL DRUGS? YES NO

FAMILY MEDICAL HISTORY

Mother	Father		Mother	Father		Mother	Father	
_____	_____	Alzheimer's Disease	_____	_____	Diabetes Mellitus	_____	_____	Liver Problem
_____	_____	Anemia	_____	_____	Disorder of Thyroid Gland	_____	_____	Cancer
_____	_____	Arthritis	_____	_____	Epilepsy(Seizures)	_____	_____	Osteoporosis
_____	_____	Asthma	_____	_____	Headache	_____	_____	Rheumatoid Arthritis
_____	_____	Stroke	_____	_____	Heart Disease	_____	_____	Ulcer
_____	_____	COPD	_____	_____	High Cholesterol			
_____	_____	Dementia	_____	_____	High Blood Pressure			

ALLERGIES TO MEDICATIONS:

_____ Penicillin
_____ Morphine
_____ Demerol
_____ Codeine
_____ Novocaine
_____ Latex
_____ Sulfa Drugs
_____ Adhesive Tape
_____ Shrimp. Iodine, Merthiolate
_____ Aspirin
_____ Dye
_____ Tetanus

ANY OTHER MEDICATION ALLERGIES: _____

PATIENT'S PHYSICIANS INFORMATION

PHYSICIAN NAME _____ LOCATION & PHONE NUMBER _____

THE NAME OF YOUR PHARMACY: _____ PHONE NUMBER _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE MY PERMISSION TO THE DOCTOR TO ADMINISTER AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FEET.

PATIENT'S SIGNATURE OR SIGNATURE
OF PARENT OR GUARDIAN_____ DATE_____