WELCOME TO OUR PRACTICE

PATIENT INFORMATION:

First Name_____ Last Name_____ MI____

Social Security#_____-_____-_____ Birthdate_____/_____/_____ Age_____

Address:_____ City_____ State____ Zip_____

Home Phone ( )_____ Cell( )_____Work( )_____

e-mail address_____

Marital Status M / S / W / D Race: Caucasian / African American / Other _____

Primary Language Spoken: English, Spanish, Other_____ MALE / FEMALE

EMPLOYER:

Name_____ Address:_____

SPOUSE____ PARENT____ GUARDIAN____ (please check one that applies)

Name:_____ Birthdate_____/_____/_____

Social Security#_____ Phone#_____

EMERGENCY CONTACT:

Name:_____ Relationship _____

Phone#( )_____

Who are we permitted to talk to, other than you, regarding appointments, insurance/claims or test results

Name:_____ Relationship_____

MAYSVILLE FOOT & ANKLE CLINIC AUTHORIZATION OF RECEIPT NOTICE OF PRIVACY PRACTICE

I hereby acknowledge the receipt of the Notice of Privacy regarding my Protected Health Information

_____

SIGNATURE DATE

AGREEMENT TO TERMS OF MAYSVILLE FOOT & ANKLE CLINIC PAYMENT POLICIES

The primary insurance will be contacted to verify deductible and/or copay information. Services and/or DME items will be checked for coverage as well. Please be aware that NO GUARANTEE has been made to the office that testing or services will be reimbursed. Just because we ***participate*** that does not mean your insurance will cover our services or your diagnosis.

For patient convenience, this office will file appropriate insurance claim(s) and one appeal if necessary. The staff will work with the insurance company for a period of sixty (60) days from the date of service. At that time, payment will be expected from the patient and our staff will provide information to the patient for continued pursuit with their insurance.

Regardless of the insurance situation, charges are expected to be paid in full ninety (90) days from the date they are rendered. Non-payment of the patient balances may be reported to a collection agency.

NON-COVERED SERVICES

Services not covered by insurance or medical assistance must be paid the day services are rendered. You will be notified of these services prior to your treatment.

KENTUCKY MEDICAID OR KenPac COVERAGE

All Medicaid only patients must be referred from their primary care physician. Medicaid coverage will be verified prior to or the day services are rendered. At that time, copay information will be verified as well as KenPac provider.

PPO, HMO, COMMERCIAL , PRIVATELY OWNED INSURANCE

All co-pays and deductibles are expected at the time of service. **Referrals are the sole responsibility of the patient.** Failure to present an insurance referral may result in the appointment being rescheduled to a time where the referral can be obtained or the patient may choose to be seen as a "CASH" patient that day and pay the charges in full.

CHILDREN OF SEPARATED / DIVORCED PARENTS:

The parent responsible for the initial contact with our office will be responsible for the payment of our services. We regret that we cannot become more involved in collecting from other parent.

NO SHOW FEE

We enforce a **$20 no show fee** for patients who do not call to cancel their appointment. Please be courteous and call to cancel or reschedule your appointment as far in advance as possible, as we have a waiting list of patients to contact.

SELF PAY

Self pay patients are made aware at the time the appointment is schedule that they will be responsible for charges the day they are seen. NO EXCEPTIONS...

I have reviewed the reverse side of this form and have read and agree to the specific office policies pertaining to my particular insurance coverage(s). If my insurance is MEDICARE/MEDICAID, I hereby request that payment of authorized Medicare/Medicaid benefits be made on my behalf to Maysville Foot & Ankle Clinic, Dr. Marc Pawsat, for any services I receive. I authorize *any holder* of medical information about be to be released to the Health Care Financing Administration (HCFA), and its agents, any information needed to determine these benefits or the benefits payable for related services. I understand my signature request that payment be made and authorizes the release of medical information necessary to pay the claim. If "other insurance" is indicated in item (of the CHCA-1500 form, or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorized the release of information to the insurer or agency shown. In Medicare/Medicaid assigned cases, the Specialist agrees to accept the charge determination of the Medicare/Medicaid carrier as the full charge, and **I am responsible for any deductible, co-insurance and non-covered services.** If my insurance is other than Medicare/Medicaid I, the undersigned, certify than I (or my dependant) have insurance coverage as listed above and assign directly to Maysville Foot/Ankle Clinic, Dr. Marc Pawsat, 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 the use of my signature on all insurance submissions for the period of LIFETIME. I authorize and direct the insurance carrier(s) to issue payment check(s) directly to Maysville Foot & Ankle Clinic.

SIGNATURE_____ **DATE**_____

CURRENT AND PAST MEDICAL HISTORY

Name: _____ Date: ___/___/___

Family Physician: _____

REASON FOR APPOINTMENT: _____

HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING: (CHECK YES OR NO)

YES	NO		YES	NO		YES	NO	
___	___	BLEEDING DISORDER	___	___	HIGH CHOLESTEROL	___	___	RHEUMATIC FEVER
___	___	CANCER	___	___	INGROWN TOENAILS	___	___	RHEUMATOID ARTHRITIS
___	___	DIABETES	___	___	KIDNEY DISORDER	___	___	SEIZURES
___	___	FOOT/ANKLE SURGERY	___	___	LIVER DISORDER	___	___	STOMACH AILMENT
___	___	FRACTURE FOOT/ANKLE	___	___	LUNG DISORDER	___	___	STROKE
___	___	HEART DISEASE	___	___	OSTEOARTHRITIS	___	___	THYROID DISORDER
___	___	HIGH BLOOD PRESSURE	___	___	PLANTAR WARTS	___	___	ULCER FOOT/LEG

PAST SURGICAL HISTORY: _____

_____

SOCIAL HISTORY:

Tobacco use: Current smoker (YES / NO) OR Past history of smoking (YES / NO)

Alcohol consumption _____Not at all _____Occasionally/Socially _____ Daily

Recreational drugs _____Not at all _____History of addiction

FAMILY HISTORY: Please check all that apply

	(Mother /	Father /	Sibling)
Diabetes	___	___	___
Cancer	___	___	___
Stroke	___	___	___
Heart Disease	___	___	___
High Blood Pressure	___	___	___
Kidney disease	___	___	___

CURRENT MEDICATION: _____

_____

_____

_____

DRUG ALLERIGIES: _____

HOW DID YOU HEAR ABOUT US?

___Dr. Referral ___Internet ___Family/Friend ___Hospital/ER ___Yellow Pages ___Other: _____