NEW PATIENT INFORMATION

_____ _____

(Last) (First) (M)

_____

(Address) (City) (State) (Zip)

Date of Birth _____Age_____ SS# _____-_____-_____ Phone:_____ Cell:_____

Email:_____ May we contact you via email? YES / NO

Preferred Method of Contact for Reminders: Call Text Email For Statements: Email US Mail

(CIRCLE ONE) *Male / Female* Married: *Yes / No* Student: *Yes / No*

Referrals *Primary Physician:* _____ *Date Last Seen:* _____

REFERRING PHYSICIAN (IF ONE): _____

Employment

Employer: _____ Phone: _____ Full Time / Part Time

Address: _____ Occupation:_____

Guarantor Information (person who carries insurance/Guardian to a minor)

Name: _____ DOB:_____ Phone:_____

Address: _____ _____Relationship to patient_____

Guarantor's Employer:_____ Guarantor's SS#:_____

How Did You Hear About Us?? Please circle

Google/Websearch *Provider Office* *My Doctor* *Church Bulletin* *My Insurance Company* *Emergency Room*

Newspaper Phone Book Sign Coworker Friend One of our Patients Email Advertisement

Insurance

Please provide us with a copy of your current insurance card. It is also your responsibility to inform us of any changes in your coverage.

➔ *PLEASE READ AND SIGN*:

I authorize the Bluegrass Foot Center and its doctor, to examine and treat me, and for them to bill my insurance company. Payment should be made directly to the Bluegrass Foot Center.

I understand that my insurance may require certain referrals or that a physician be within a certain provider network, and that any non-compliance of these restrictions may result in reduced or eliminated benefits.

I realize that I am responsible for payment of all fees incurred for my care although I may have insurance that may cover all or part of the cost of such care. I understand that I am responsible for any charges that may be applied to my insurance deductible, coinsurance, or services not covered by my policy. I agree to pay for any collection fee, court costs, attorney and legal fees if it becomes necessary in collecting any outstanding balance.

I authorize the Bluegrass Foot Center to release any information or records acquired in the course of my examination or treatment to my insurance company or other medical professionals as necessary for my treatment.

This authorization shall remain in effect until it is revoked by me.

Signature_____ Date_____

*Medicare / MediGap Authorization (Signature on File) *only sign if you have Medicare**

If I qualify for Medicare or Medigap (Medicare Supplement), I request that the payment of authorized benefits be made to Bluegrass Foot Center for any services furnished. I authorize any holder of medical information about me to release to the HCFA and it's agents any information to determine those benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature_____ Date_____