PODIATRY CENTER PATIENT REGISTRATION

PATIENT NAME____
FIRST MIDDLE LAST

STREET ADDRESS____

CITY___________________________STATE_________ZIP CODE_______________________

MALE________ FEMALE________ PREFERRED LANGUAGE:_________________________

ETHNICITY/RACE: HISPANIC OR LATINO ☐

AMERICAN INDIAN OR ALASKAN NATIVE ☐ WHITE ☐ ASIAN ☐

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER☐

BLACK OR AFRICAN AMERICAN ☐

OTHER ☐ ____

HOME
PHONE_____________________CELL________________________WK_________________

EMAIL ADDRESS:____

DATE OF BIRTH: MONTH ___________ DAY___________ YEAR___________

REFERRING DOCTOR ____________________DIABETIC DOCTOR____________________

NEAREST RELATIVE, PHONE NUMBER____

WHOM MAY WE THANK FOR REFERRING

YOU TO THIS OFFICE?____

OFFICE POLICY ON PAYMENT

CO-PAYMENT ON YOUR HEALTH INSURANCE IS DUE AT THE TIME OF SERVICE UNLESS OTHERARRANGEMENTS HAVE BEEN MADE. AS A COURTESY, WE WILL BILL BOTH YOUR PRIMARY AND SECONDARY INSURANCE PROVIDED ALL BILLING INFORMATION HAS BEEN SUBMITTED AT THE TIME OF YOUR VISIT. IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE COVERAGE REGUARDING X-RAYS, EXAMS AND MAJOR SERVICES. IT IS IMPOSSIBLE FOR US TO KNOW THE COVERAGE OF ALL INSURANCE PLANS. WE WILL DO THE BEST WE CAN IN RETRIEVING YOUR BENEFITS. HOWEVER, PREVISIONS AND EXCLUSIONS SUCH AS NON- ALLOWED CHARGES, NON COVERED SERVICES, ORTHOTICS, NOT MEDICALLY NECESSARY SERVICES OR OTHER FACTORS MAY COME INTO PLAY. WE RESERVE THE RIGHT TO CHARGE INTEREST ON YOUR ACCOUNT AT THE RATE OF 1.5% PER MONTH ON ANY BALANCE OF 60 DAYS OR MORE. COLLECTION FEES AND RELATED EXPENSES (INCUDING ATTORNEY FEES) WILL BE THE RESPONSIBILITY OF THE PATIENT. I AUTHORIZE PAYMENT OF THE MEDICAL BENEFITS TO THE PHYSICIAN HEREIN FOR MEDICAL SERVICES RENDERED. A PHOTOCOPY OF THIS SIGNATURE IS VALID AS AN ORIGINAL. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED FOR THE PROCESSING OF THE INSURANCE FORM.

SIGNATURE____DATE_______________________