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DPM, PLLC.

ADULT Registration forms

Today's Date:_____

Patient's Name: _____

Patient's Date of Birth:_____ **Patient's Sex**: ☐Male ☐Female

Patient's Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Patient's Address:_____Apt#:_____

City:_____State:_____Zip Code :_____

Primary ph #: _____Home#: _____ Cell#: _____
**Do you give consent to receive automated reminder calls & texts on your cell phone? ☐YES ☐No

Email Address: _____
Our online Patient Portal allows you to request appointments, make payments by credit card online 24/7, exchange secure messages with the care team, etc. Would you like to have access to our online Patient Portal?
☐YES, I DO want access to the Portal ☐No, I do NOT want access to the Portal

Employer: _____ Occupation: _____

How did you hear about us? _____

Family Physician or PCP: _____ Date of Last Visit: _____

Has your Doctor requested that you be seen in our office? ☐YES ☐No

Former Podiatrist: _____

Why did you see your former podiatrist?_____

What brings you to our office?_____

_____

_____

_____

Which foot? (please check one) : ☐ RIGHT only ☐ LEFT only ☐ BOTH Right & Left

***Is this condition related to a work injury or an injury that happened while on the job?** ☐YES ☐No

FOR WOMEN ONLY: Are you pregnant? Yes / No If yes, how many months?_____

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We must be provided with information and cards for <u>ALL</u> insurances available for the patient, even if the patient is eligible for Medicare and/or Medicaid. There are insurance rules which determine which insurance is primary and we must follow those rules. Failure to give us all insurance information may result in claims not being paid.

#1 - PRIMARY (#1) INSURANCE: Is this insurance through an employer? ☐ NO ☐ YES

Name of Insurance:_____Employer Name:_____

Name of Policy Holder:_____ Phone # :_____

Date of Birth:_____ Sex: M / F Policy Holder SSN#:_____

Patient's relationship to the Policy Holder : ☐ Self ☐ Spouse ☐ Child ☐ Step-child

#2 - SECONDARY (#2) INSURANCE: Is this insurance through an employer? ☐ NO ☐ YES

Name of Insurance:_____Employer Name:_____

Name of Policy Holder:_____ Phone # :_____

Date of Birth:_____ Sex: M / F Policy Holder SSN#:_____

Patient's relationship to the Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Step-child

#3 - TERTIARY (#3) INSURANCE: Is this insurance through an employer? ☐ NO ☐ YES

Name of Insurance:_____Employer Name:_____

Name of Policy Holder:_____ Phone # :_____

Date of Birth:_____ Sex: M / F Policy Holder SSN#:_____

Patient's relationship to the Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Step-child

INSURANCE RELEASE AND ASSIGNMENT

TO MY INSURANCE CARRIER(S):

1. I authorize the release of any medical information necessary to process my insurance claim (s).
2. I authorize and request payment of medical benefits directly to my physicians.
3. I agree that is authorization will cover all medical services rendered until such authorization is revoked by me.
4. I agree that a photocopy of this form may be used in lieu of the original.

_____ _____

Printed Name of person signing this form Relationship to Patient

_____ _____

Signature of Patient, Guardian or Authorized Party Date Signed

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EMERGENCY CONTACT (Not living with patient):

Name:____ Phone: ______________________________

Relationship to Patient: ____

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MEDICATION HISTORY CONSENT

☐YES, I DO give my permission ☐No, I do NOT give my permission

For **DR. CHARLES PITTLE DPM PLLC** to access my Pharmacy benefits data electronically in order to:

- Check whether a prescribed medication may be covered under my plan.
- Download a historic list of all medication prescribed for a patient by any provider.

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Please list **ALL medications & supplements** you currently take: ______________________________________

____

____

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____

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Please **circle** **"No"** or **"YES"** for each of the following**:**

Allergic to **ANY Med(s)** or **Food(s):**	NO	**YES >**	**If YES,** please list **ALL:**				
ADD or ADHD (Attention Deficit/ Hyperactivity Disorder)	NO	**YES**		**Kidney Disease**	NO	**YES**	
AIDS/HIV	NO	**YES**		**Leg or Foot Ulcers**	NO	**YES**	
Autistic or Autism Spectrum Disorder	NO	**YES**		**Liver Disease**	NO	**YES**	
Autoimmune Disorder	NO	**YES >**	**If YES,** which?	**Lung Disease**	NO	**YES**	
Back Pain	NO	**YES**		**Mental Illness(s)**	NO	**YES >**	**If YES,** which?
Bleeding Disorder	NO	**YES**		**Methicillin-Resistant Staphylococcus Aureus** [Also known as: MRSA]	NO	**YES >**	**If YES,** when?
Blood Clots	NO	**YES**		**Organ Transplant**	NO	**YES**	
Cancer	NO	**YES >**	**If YES,** where?	**Osteoporosis**	NO	**YES**	
Coronary Artery Disease	NO	**YES**		**Pacemaker**	NO	**YES**	
DVT (Deep Vein Thrombosis)	NO	**YES**		**Peripheral Vascular Disease**	NO	**YES**	
Dementia	NO	**YES**		**Polio**	NO	**YES**	
Diabetes	NO	**YES >**	**If YES**, which? PRE Type 1 Type 2	**Pulmonary Embolism**	NO	**YES**	
Dialysis	NO	**YES**		**Raynaud's Disease**	NO	**YES**	
Down Syndrome	NO	**YES**		**Rheumatoid Arthritis**	NO	**YES >**	**If YES**, where?
Fibromyalgia	NO	**YES**		**Seizures / Epilepsy**	NO	**YES**	
GERD (Gastroesophageal Reflux Disease or Acid Reflux)	NO	**YES**		**Stroke**	NO	**YES**	
Heart Disease or Heart Attack(s)	NO	**YES**		**Thyroid Disorder**	NO	**YES**	**If YES**, which? Hypo Hyper
Hepatitis A-B-C	NO	**YES >**	**If YES,** which? **A B C**	**TB - Tuberculosis**	NO	**YES**	
High Blood Pressure / Hypertension	NO	**YES**		**Varicose Veins**	NO	**YES**	
Any other illnesses or conditions NOT listed?	NO	**YES >**	**If Yes**, please provide details:				

SERIOUS SURGERIES: Please provide details below:

Operations / Surgeries	**Date/Year**	**Physician Name**	**Hospital Name**

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FINANCIAL CONSENT: Please thoroughly read each policy, initial next to each policy and sign below:

Initials

Treatment Agreement

____ I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

Release of Information

____ For the purpose of payment, I allow ***Charles Pittle, DPM, PLLC*** to release my Private Health Information to any and all of my insurance carriers, their third party payors and claim reviewers, until the claim is resolved. For the purpose of treatment, I also allow the above listed practice to release my information or contact any and all of my treating physicians.

Acknowledgement of Receipt of Notice of Privacy Practices

____ I acknowledge that I was provided a copy of the HIPAA Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice. The ***Charles Pittle, DPM, PLLC*** HIPAA rights are also posted in lobby and at www.charlespittledpm.com.

Financial Policy

____ You must provide personal (address, phone numbers, etc.) and/or insurance changes (carriers, networks, id numbers, etc.) to the office at least 2 days prior to your appointment. In the event the office is not informed, you will be responsible for any charges denied.

____ A current insurance card for ALL insurances must be presented at every visit. If you have Medicare &/or Medicaid & an employer insurance, you are required by law to give us both.

____ **You are responsible for all authorizations/referrals/pre-certifications** needed to seek treatment with ***Charles Pittle, DPM, PLLC*** physicians. If you are not certain if these are required, please contact your insurance company *before* your appointment.

____ **Your portion of payment for ALL office services is due at the time of service**. We accept VISA, MasterCard, Discover, American Express, Money Orders, cash or personal check.

____ Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you with an assignment of benefits. You are agreeing to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, the patient or guardian seeking care for a minor, will be responsible for payment of services.

____ **If your claim is not paid because you did not provide us with your current and correct insurance information, the balance will be your full responsibility to pay.**

____ We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and **will require you to pay the co-pay/co-insurance/deductible at the time of service**. Your upfront portion will be calculated based on your insurance benefit/limits and our negotiated fee agreement with your carrier. If you are seeing our doctors on an "Out of Network" basis, you will be subject to out of network rates.

____ Not all services are a "covered" benefit in all insurance policies; some plans even impose a waiting period before covering services. In the event your health plan determines a service to be "not covered/pre-existing," or you do not have an authorization, you will be responsible for all charges. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. **Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.**

____ ***We can NOT bill to any Worker's Compensation plan**. We also cannot bill to a private insurance or Medicaid or Medicare for an injury that happened while on the job or is work related. If your injury happened while on the job or is work related, you will be responsible for all charges related to the care of the condition.

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FINANCIAL CONSENT continued: Please thoroughly read each policy, initial next to each policy and sign below:

Initials

____ **Pre-scheduled surgical procedures require pre-payment/estimated deposit. Your deductible/co-insurance/co-pay for this procedure is due at the pre-operative appointment.** For other services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

____ We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Any payment exceptions will be agreed upon in writing.

____ **PAST DUE accounts are subject to collection proceedings** including the credit bureau. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due to this office.

____ Accounts no longer maintaining a financial "Good Faith" status may result in the termination of the ***Charles Pittle, DPM, PLLC*** Doctor-Patient relationship.

____ There is a service fee of $35.00 for all returned ("bounced") checks. Upon an NSF or CLOSED ACCOUNT occurrence, all future remittances will need to be in other forms of payment. Restitution of "Theft-by-Check" will be requested from the District Attorney's Office. If more than one (1) check is returned, we will not accept any additional checks and will require payment in cash or by credit card.

____ ***Charles Pittle, DPM, PLLC*** issues patient refund checks within 90 days of a completed investigation of the potential overpayment.

____ **ONLY UNWORN and NON-custom items are returnable within 3 days of receipt. Custom items are non-returnable.**

Appointments

____ **24 hours notice is requested for appointment cancellation.** Appointments where less than 24 hours notice is given may result in a $25 "No Show" charge to the account. Repetitive broken or cancelled appointments and/or non-compliance may result in the patient being dismissed from the practice.

____ **To help us stay on schedule, we ask that ALL NEW PATIENTS (or any patient not seen in the last 3 years or more) arrive to our office AT LEAST 15 minutes BEFORE their scheduled appointment time and no later than their appointment time. ESTABLISHED PATIENTS, if you are more than 15 minutes late, we may need to reschedule your appointment.** If possible, we will work you into the same day's schedule, but please be advised that other scheduled patients may be seen before you.

____ **Patients are seen by appointment time. If you arrive early for your appointment time, we may see patients who have scheduled appointments before you first.**

Authorization of Payment

____ I hereby assign all Medical benefits directly to ***Charles Pittle, DPM, PLLC*** for the payment of any services rendered. I also authorized release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay for the services I received, I will be financially responsible for payment.

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or a supervisor.

_____ _____

Printed Name of person signing this form | Relationship to Patient

_____ _____

Signature of Patient, Guardian or Authorized Party | Date Signed

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Full Name: _____

Patient's Date of Birth:_____/ _____/_____

I request and authorize Dr. Charles Pittle DPM PLLC (Dr. Charles Pittle & Dr. Amy Bodart, Foot Specialists) **to release healthcare information of the patient named above to:**

FULL Name of YOUR Doctor, Primary Care Physician (PCP) or Pediatrician:

_____

Address: _____ Suite #: _____

City: _____ State: _____ Zip Code : _____

Phone #: (_____)_____ Fax #: (_____)_____

Please send copies of the following Medical Records (check all that apply):

___ Entire Medical Records

___ Pathology report(s) ONLY

___ Office Consult notes ONLY

___ Lab results/reports ONLY

___ Other:_____
(please specify

I understand I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

I understand that if the person or entity that receives the described records/information is not subject to federal privacy regulations or other laws, the records/information may be re-disclosed and no longer protected by those regulations.

I understand that the healthcare provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may refuse to sign this authorization.

_____ _____
Printed Name of person signing this form Relationship to Patient

_____ _____
Signature of Patient, Guardian or Authorized Party Date Signed