charlespittle
DPM, PLLC.

CHILD Registration forms (Patients under 18 years of age) Today's Date: _____

_____ _____

Name of person completing these forms **Relationship to Patient**

Patient's Full Name: _____

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

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

Patient's Address:_____Apt#:_____

City:_____State:_____Zip Code _____

Patient lives with: ☐BOTH PARENTS ☐MOTHER ☐FATHER ☐OTHER: _____

Primary phone #:_____Home #:_____Cell #:_____
Do you give consent to receive automated reminder calls/texts on your cell phone? ☐Yes ☐No

How did you hear about us? _____

Patient's Pediatrician 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

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

For Staff Use Only: Form Reviewed by: _____ November 4, 2015

charlespittle
DPM, PLLC.

We must be provided with information and cards for ALL 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 INSURANCE:

Is this insurance through an employer? ☐ NO ☐ YES

Name of Insurance Company:_____Employer:_____

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 INSURANCE:

Is this insurance through an employer? ☐ NO ☐ YES

Name of Insurance Company:_____Employer:_____

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 INSURANCE:

Is this insurance through an employer? ☐ NO ☐ YES

Name of Insurance Company:_____Employer:_____

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.

_____ Date: _____

Signature of Patient, Guardian or Authorized Party

For Staff Use Only: Form Reviewed by: _____ November 4, 2015

Mother's Name: ____ Phone: ____________________________

Mother's Date of Birth:____ Marital Status: M / S / D / W

Address:____ Apt #:_____________________________

City:____State:_________________ Zip Code :_____________________________

Employer: ____ Work Phone:______________________________

Does the patient have insurance through this employer? ☐NO ☐ YES

Father's Name: ____ Phone: ____________________________

Father 's Date of Birth:____ Marital Status: M / S / D / W

Address:____ Apt #:_____________________________

City:____State:_________________ Zip Code :_____________________________

Employer: ____ Work Phone:______________________________

Does the patient have insurance through this employer? ☐NO ☐ YES

EMERGENCY CONTACT (Not living with patient):

Name:____ Phone: ____________________________

Relationship to Patient: ____________________________________ Phone: ____________________________

+

MEDICATION HISTORY CONSENT

☐ YES, I 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 is covered under a patient's plan.
- Download a historic list of all medications prescribed for a patient by any provider.

+

Please list **ALL medications & supplements** the patient currently takes: ____________________________________

____

____

____

____

____

charlespittle
DPM, PLLC.

Please circle "Yes" or "No" for each of the following:

Allergic to ANY Medication(s):	NO	**YES**	If YES, please list ALL:				
AIDS/HIV	NO	**YES**		**Kidney Disease**	NO	**YES**	
Back Pain	NO	**YES**		**Leg or Foot Ulcer (currently or a history of)**	NO	**YES**	
Bleeding Disorder	NO	**YES**		**Liver Disease**	NO	**YES**	
Blood Clots	NO	**YES**		**Lung Disease**	NO	**YES**	
Cancer	NO	**YES**	If YES, which?	**Organ Transplant**	NO	**YES**	
Coronary Artery Disease	NO	**YES**		**Osteoporosis**	NO	**YES**	
Deep Vein Thrombosis	NO	**YES**		**Pacemaker**	NO	**YES**	
Dementia	NO	**YES**		**Peripheral Vascular Disease**	NO	**YES**	
Diabetes	NO	**YES**	If YES: Type 1 Type 2	**Polio**	NO	**YES**	
Dialysis	NO	**YES**		**Pulmonary Embolism**	NO	**YES**	
Down Syndrome	NO	**YES**		**Raynaud's Disease**	NO	**YES**	
Fibromyalgia	NO	**YES**		**Rheumatoid Arthritis**	NO	**YES**	If YES, where?
Foot Deformity	NO	**YES**		**Seizures Epilepsy**	NO	**YES**	
Heart Disease	NO	**YES**		**Stroke**	NO	**YES**	
Hepatitis	NO	**YES**	If YES: A B C	**Tuberculosis**	NO	**YES**	
Hypertension (High Blood Pressure)	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

For Staff Use Only: Form Reviewed by: _____ November 4, 2015

charlespittle
DPM, PLLC.

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 may request 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. This notice is posted in the office 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.**

charlespittle
DPM, PLLC.

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.

____ **If you are more than 15 minutes late for your appointment, we may ask you to reschedule your appointment.** If possible, we will work you into the schedule, but please be advised that other patients with appointments will be seen before you.

____ **Patients are seen by appointment time. If you arrive early for your appointment time, we will 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.

_____ Date: _____

Signature of Patient, Guardian or Authorized Party

For Staff Use Only: Form Reviewed by: _____ November 4, 2015