DIABETIC & ATHLETIC FOOT CENTER

WELCOME TO THE DIABETIC & ATHLETIC FOOT CENTER

PATIENT INFORMATION SHEET

FIRST NAME:_____ MI:_____ LAST NAME:_____

STREET ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____ SSN:_____-_____-_____

HOME#:_____CELL#:_____WORK#:_____

D.O.B:_____ SEX: M/F HEIGHT:_____ WEIGHT:_____ MARITAL STATUS: S/M/W/D

EMAIL ADDRESS:_____

EMERGENCEY CONTACT NAME:_____ PHONE#:_____
RELATIONSHIP:_____

***REFERRING PHYSICIAN:**_____**PHONE#:**_____

***PRIMARY CARE PHYSICIAN / ENDOCRINOLOGIST**
LIST THE DR WHO TREATS FOR DIABETES:_____**PHONE#:**_____

PRIMARY INSURANCE

PROVIDER:_____ID #:_____

GROUP #:_____EMPLOYER NAME:_____PHONE #:_____

POLICY HOLDER NAME:_____D.O.B:_____RELATIONSHIP:_____

SECONDARY INSURANCE

PROVIDER:_____ID #:_____

GROUP #:_____EMPLOYER NAME:_____PHONE #:_____

POLICY HOLDER NAME:_____D.O.B:_____RELATIONSHIP:_____

I hereby authorize treatment by Diabetic & Athletic Foot, LLC Center as prescribed by my physician. I certify the information provided is true and correct. I will notify Diabetic & Athletic Foot Center, LLC of any changes in the above information, including insurance coverage, in a timely manner.

_____ _____

Signature of Patient or Legal Guardian Date

DIABETIC
FOOT CENTER

"Your Ultimate Source For Diabetic Foot Care"

245 Fries Mill Road
Sewell, NJ 08012

toll free 855.FIT.4YOU
855.348.4968
office 856.582.3968
fax 856.582.3967

www.diabeticfootcenter.net

Authorization to Release Healthcare Information

Patient Name:_____

Date of Birth:_____

I hereby request and authorize the Diabetic & Athletic Foot Center to receive my medical documentation pertaining to my medical condition.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian

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Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The Notice of privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Diabetic & Athletic Foot Center health care operations. The Notice of Privacy Practices also describes my rights and Diabetic & Athletic Foot Center duties with respect to my protected health information. The Notice of Privacy Practices is posted at patient waiting area.

Diabetic & Athletic Foot Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Legal Guardian Date

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Assignment of Insurance of Benefits

I certify that the information given by me is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered services rendered by Diabetic Foot Center, LLC to Diabetic Foot Center LLC and authorize Diabetic Foot Center LLC to submit claims to Medicare, Medicaid and/or commercial insurance carriers for payment. I authorize payment of my insurance benefits directly to Diabetic Foot Center, LLC. Which payment will not exceed the balance due on my account. I hereby guarantee payment to Diabetic Foot Center, LLC of any and all changers not covered by this assignment and waive any and all notice and demands in the event of non-payment there under.

Financial Responsibility Statement

Medical insurance is a contract between you, your employer and your insurance company. We will submit the necessary information to your plan in an attempt to obtain prior authorization for any service provided we know such authorization is required under your plan. The information provided us by your insurance company is never a guarantee of payment or benefit levels. We often find the information provided is incorrect and benefit levels are not truly examined by your insurance company until they process a claim for payment.

Please understand that Medicare, Medicaid, and other insurance carriers may not fully cover our services. They may deem the services we provide and prescribed by your physician, as not medically necessary even when you and your physician feel the services are necessary. They also may limit the quantity of services they cover within a given period of time. The information you provide us concerning your prior treatment history is important, as any omissions or false information may lead us to provide services that would not otherwise be covered. You are responsible for payment of all serviced provided even when your insurance company say you are not responsible for the balance if it is a result of failing to provide and accurate and complete prior treatment history.

Not all services are covered benefits in all contracts. Some insurance companies select certain services they will not cover, and regardless of our participation with a plan, payment for any non-covered services will be the patient's responsibility.

If a service provided is not a covered benefit for my plan or if the professional fee exceeds the insurance payment. I understand that I am responsible for the balance.

We emphasize that as a medical care provider, our relationship is with you, our patient, and not your insurance company. We cannot be responsible for the uncovered benefits of your plan. It is your responsibility to know your policy.

If any balance is not paid due when due, I agree to pay all cost of collection , including reasonable attorney fees and court costs as well as interest charges, at the maximum rate allowable by law, on the unpaid balance.

I have read and understand this financial statement and realize that the fees, regardless of insurance coverage, are ultimately my responsibility.

Signature of Patient or Legal Guardian _____ Date _____

Print name of Patient or Legal Guardian _____ Date _____