PATIENT INFORMATION

(CONFIDENTIAL INFORMATION- IMPORTANT FOR OUR FILES AND YOUR HEALTH)

PATIENTS NAME_____

AGE _____ **BIRTHDATE**_____ **M/F (CIRCLE) MARTIAL STATUS** _____

ADDRESS_____ **PHONE**_____

CITY/STATE/ZIP_____ **CELL PHONE#** _____

EMAIL ADDRESS _____

OCCUPATION _____ **SOC SEC#** _____

PATIENT EMPLOYED BY_____**WORK #**_____

BUSINESS ADDRESS_____

SPOUSE NAME_____ **SPOUSE BIRTHDATE**_____

PARENT/SPOUSE EMPLOYER_____**WORK#**_____

IF PATIENT UNDER 18, PARENTS NAME_____**BIRTHDATE**_____

PARENT ADDRESS, IF DIFFERENT FROM ABOVE_____

NEAREST RELATIVE NOT LIVING WITH YOU_____**PHONE**_____

FAMILY DOCTOR_____**LAST VISIT**_____**PHONE**_____

FORMER PODIATRIST_____**PHONE**_____

PERSON TO CONTACT IN EMERGENCY_____**PHONE**_____

REFERRED BY_____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

I WILL BE PAYING TODAY BY CASH _____ **CHECK** _____ **VISA/MASTERCARD** _____

FINANCIAL POLICY

We are pleased that you have chosen is as your foot care specialist. We at Lakeview Family Foot Care LLC are committed to your treatment being successful and are certain you will be happy with the care provided by our staff. All patients must complete our Patient information sheets prior to being examined.

INSURANCE: As a convenience to our patients, we submit claims to your insurance company. We must have the correct and complete insurance information at the time of service in order to file with your insurance company in a timely manner. If you do not have all required insurance information, and you choose to be seen by the doctor, it is understood that you will be responsible for satisfying the charges for the services rendered.
Co- pays, deductibles and services not covered by your insurance will need to be paid at the time of service. Your insurance policy is a contract between you and your insurance company. In the event that your insurance company has not paid your account with in 45 days, the responsibility to pay will be transferred to you. We will assist you in any way with your insurance company to settle your balance, however, it is your responsibility to know and be aware of your insurance plan coverage, deductibles, co-pays and limitations. If your balance remains unpaid for 60 days, and interest of 15% may be added to your outstanding balance. If your balance remains unpaid for longer than 60 days, we have the right to forward your account to our collection agency. If your account is forwarded to collections, you will be responsible for an additional $15.00 fee in addition to the collection agency fees accumulated for this service.

PRIVATE PAY/SELF PAY: In order to help our patients during difficult financial times, we agree to accept half of the balance due at the time of service, and we will set up payment arrangements in the form of a payment plan for the remaining balance. Should a surgical procedure(s) be done, half of the fee must be paid prior to the surgery procedure and that remaining balance paid the day of the surgery. If the patient fails to pay according to the payment plan and fails to contact our office, the account may be forwarded to a collection agency. If your account is forwarded to a collection agency, you will be responsible for a $15.00 service fee in addition to the collection agency fees accumulated for this service.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You will be responsible for payments that your insurance considers allowable, however, based on your contract will, only pay a portion or a percentage. Thank You for reviewing our Financial Policy. Please let us know if you have any questions.

I HAVE READ THE FINANCIAL POLICY AND HEREBY AUTHORIZE LAKEVIEW FAMILY FOOTCARE, LLC TO APPLY ON MY BEHALF FOR SERVICES RENDERED. I REQUEST THAT PAYMENT BE MADE DIRECTLY TO LAKEVIEW FAMILY FOOTCARE, LLC. I CERTIFY THE INFORMATION I HAVE GIVEN IS ACCURATE AND CORRECT. I AUTHORIZE LAKEVIEW FAMILY FOOTCARE TO RELEASE ANY MEDICAL DOCUMENTATION REQUIRED FOR THE TREATMENT OR PAYMENT FOR MY SERVICES I UNDERSTAND ANDACKNOWLEDGE THIS STATEMENT.

_____ _____

Signature of Patient or responsible party **Date**

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

Name of Insurance _____
Name of Policy Holder_____
Policy Holders date of Birth_____
Relationship of Patient to insured_____
Contract#_____ Group#_____

SECONDARY INSURANCE INFORMATION

Name of Insurance _____
Name of Policy Holder _____
Policy Holders Date of Birth_____
Relationship of patient to insured _____
Contract # _____ Group #_____

ADDITIONAL INSURANCE INFORMATION

Name of insurance _____
Name of Policy Holder _____
Policy Holders Date of Birth _____
Relationship of Patient to Insured _____
Contract # _____ Group # _____

ASSIGNMENT AND RELASE (INSURANCE OTHER THAN MEDICARE)

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH THE ABOVE INSURANCE COMPANY OR COMPANIES AND ASSIGN TO LAKEVIEW FAMILY FOOT CARE LLC ALL INSURANCE BENEFITS IF ANY OTHERWISE PAYABLE TO ME FOR SERVICE TENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE LAKEVIEW FAMILY FOOT CARE LLC TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS.

_____ _____ _____
RESPONSIBLE PARTY **RELATIONSHIP TO PATIENT** **DATE**

ASSIGNMENT AND RELEASE (MEDICARE)

I, THE UNDERSIGNED REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO LAKEVIEW FAMILY FOOTCARE LLC FOR ANY SERVICES FURNISHED TO ME BY AUTHORIZED PHYSICIANS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE HEALTH CARE FINANCING ADMINISTRATION AND AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND THAT MY SIGNATURE REQUEST THAT PAYMENTS BE MADE AND AUTHORIZED IN CASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF OTHER MEDICAL INSURANCE IN INDICATED IN ITEM 9 OF THE HCFA A 1500 FORM OR OTHER APPROVED CLAIM FORMS OR ELECTRONICALLY SUBMITTED CLAIMS, MY SIGNATURE RECLAIM OF INORMATION TO BE USED FOR AGENCY SHOWN. IN MEDICARE ASSIGNED CASES, THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF MEDICARE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURNACE AND CO-COVERED SERVICES. COINSURANCE DEDUCTIBLES ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER.

_____ _____ _____
RESPONSIBLE PARTY **RELATIONSHIP TO PATIENT** **DATE**

NO INSURNACE/ SELF PAY

I UNDERSIGNED THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL CHARGES. I ALSO UNDERSTAND THAT HALF OF THE LOCAL CHARGES MUST BE PAID AT THE TIME OF SERVICE. PAYMENT PLANS MAY BE ARRANGED FOR THE REMAINING BALANCE, WHICH IF NOT PAID, WILL BE SENT TO COLLECTION. SHOULD A SURGICAL PROCEDURE (S) BE DONE HALF OF FEE MUST BE PAID PRIOR TO SURGERY PROCEDURE AND THE REMAINING BALANCE PAID THE DAY OF THE SURGERY.

_____ _____ _____
RESPONSIBLE PARTY **RELATIONSHIP TO PATIENT** **DATE**

PHARMACY INFORMATION

The name of my pharmacy is _____ and the phone number is _____ for filling all of my pain medicine.

I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including State Board of Pharmacy, in the investigation of any possible misuse, sale of other diversion or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.

I agree that I will use my pain medicine at a rate no greater than the prescribed rate and that the use of medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused pain medicine to every office visit to Lakeview Family Foot Care L.L.C.

I WILL NOT HARASS Dr. Skaziak, staff or any employees for pain medication.

Patient Signature_____ Date_____

Physicians Signature_____ Date _____