



PATIENT REGISTRATION

Thank you for choosing our office! Please complete all three pages.

PATIENT INFORMATION

Patient Name:			
Home Address:			
City:		State:	Zip:
Sex:	Date of Birth:	SS#:	Marital Status: S,M,O or minor
E-mail:		Home Phone:	Cell Phone:
Employer Name		Work Phone:	

PERSON RESPONSIBLE FOR PAYING THE BILL

Name:		SS#:	
Home Address:		City	State Zip
Employer Name:		Work Phone:	

FAMILY PHYSICIAN INFORMATION

Name:	Phone:
Did your family physician refer you to this practice?	

HEALTH INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Carrier:		
Policy Number:		
Group Number:		
Effective Date:		
Copay:		
Policyholder Name:		
Date of Birth:		
Sex:		
Patient Relationship		

EMERGENCY INFORMATION

Emergency Contact:	
Emergency Contact's Phone #:	Emergency Contact's Relationship to Patient:

How did you hear about us? _____



CONSENT TO TREAT: I request and give consent to Eastover Foot & Ankle, P.A., it's employees and all other persons caring for me to treat me in ways they judge are beneficial to me for my health and well being. I understand that this care may include tests, examinations, medical and surgical treatment, and consultations with appropriate specialists. No guarantees have been made to me about the outcome of this care.

Signature: _____

FINANCIAL AGREEMENT: I understand that payment is due at time service is provided. I understand that Eastover Foot & Ankle, P.A., will bill most insurance carriers as a courtesy to me if proper paperwork is provided to them. Eastover Foot & Ankle, P.A. will also bill most secondary insurance companies for me if applicable. I understand that my co-payments and deductibles are due at the time of service. I understand that I am responsible for the payment of all charges not paid by my insurance company.

Signature: _____

ASSIGNMENT OF BENEFITS: I authorize payment directly to Eastover Foot & Ankle of any benefits, which would otherwise be payable to me for their services as described, realizing I am responsible to pay non-covered services. I also authorize Eastover Foot & Ankle, P.A. to release any information acquired in the course of my treatment necessary to process insurance claims. I authorize the use of this signature on all insurance forms and submissions.

Signature: _____ *Date:* _____

MEDICARE CERTIFICATION: The information provided by me in applying for payment for Social Security benefits is true and correct. I authorize the physician who treats me, to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediate carriers, or to the Professional Standards Review Organizations for processing of claims for medical benefits. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

- o Medicare regulations require that I am informed in advance of any service that may not be covered. **The following services may not be covered:**
 - **ROUTINE FOOT CARE:** The trimming, cutting or debridement of corns, nails and calluses is not a covered service. *Exceptions to the rule are:* patients with peripheral vascular disease that are being treated by their primary physician for this condition. Medicare will pay for nail debridement for patients who suffer from vascular disease every 61 days. If you receive treatment more frequently, you will be responsible for the services rendered.
 - **OTHER SERVICES:** Post Operative shoes, supplies such as bandages, medications, and shoe inserts, prescription orthotics and custom orthopedic shoes, lab handling fees.

Signature _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI):

I hereby give my consent for Eastover Foot & Ankle, P.A. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations as indicated in the Notice of Privacy Practices posted in the office. I am aware that I may also request a copy of the Notice of Privacy Practices to keep. I am also aware that if I do not give consent, or later revoke it, Eastover Foot & Ankle may decline to provide treatment to me.

I also authorize _____,
(Relationship _____)
(SS# OR DOB _____) to access my PHI on my behalf.

Signature _____ *Date* _____