habersham PODIATRY

Last Name_____First Name_____M.I._____

Name I am Called_____ Date:_____

Date of Birth_____

Mailing Address_____

City_____Zip Code_____

Phone Number_____Cell_____

Married Single Divorced Widow(er) Separated (Please circle One)

If Married, spouse's name_____

Email Address_____

Primary Insurance_____

Secondary Insurance_____

Primary Physician_____Date Last Seen_____

Employer_____

Occupation_____

Emergency Contact Name &
Relationship_____

Habersham Podiatry

Disclosure/Consent/Financial Policy

Patient Name_____Date of Birth_____

Assignment of Insurance Benefits:

____ I hereby authorize direct payment of my insurance benefit to Habersham Podiatry or the physician individually for services rendered to me or my dependents by the physician or under her supervision. Proof of valid insurance MUST be provided the same day of my visit. I understand that this is my responsibility to know my insurance benefits and whether the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any copay or balance due that Habersham Podiatry is unable to collect from my insurance carrier for whatever reason.

- We do NOT file auto, general liability, or homeowner's insurance
- It is your responsibility to notify us of any changes in your insurance

Medicare/Medicaid Insurance Benefits:

____ I certify that the information given to me in applying for payment under these programs is correct. I authorize release of any of my records that these programs may request. I hereby direct payment of my benefits to be made directly to Habersham Podiatry or the physician on my behalf.

Lab/diagnostic Services:

____ I understand that I may receive a separate bill if my medical care includes labs or any other diagnostic services. I further understand that I am financially responsible for any copay or balance due for these services if they are covered by my insurance carrier for whatever reason.

_____Payment & Financial Policy

- **We DO NOT bill insurance for supplies! Payment for supplies are due the same day they are dispensed!**
- **Any outstanding balance must be paid before your next appointment**
- **If you do NOT have insurance, payment is due in full the SAME day as your appointment.**
- **WE accept CASH, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, and CARE CREDIT**
- **There will be a $35.00 charge for returned checks**
- **Past due accounts will be subject to our collections process**

If you are unable to pay your balance in full, please contact Kristie at our office to set up payment arrangements.

Patient Signature_____Date_____

Guarantor Signature_____Date_____

REASON FOR VISIT

Name_____Date_____

Reason for Visit including……**RIGHT LEFT ANKLE FOOT TOENAILS**

Ingrown Nails	Bunion	Hammertoes	Athlete's Foot
Fungal Nails	Heel Pain	Burning Feet	Diabetic Foot Check
Callus	Pain	Sprain	Wart

Other_____

How long has the problem been present?

_____ Days _____Weeks _____ Months _____Years

Circle type of pain:

Sharp Shooting Dull Aching Tingling Numb Tender Sore Sensitive

Describe any related injury_____

_____

Underline or list everything you have tried to treat the problem:

Ice	New Shoes
Heat	Ace wrap
Soaking in hot water	Advil, Aleve, Tylenol
Arthritis Cream	Trimming
Dr Scholl's arch supports/gel heel pad	Callus remover
Other over the counter arch supports	Stretching
Custom Orthotics	Rolling ball under arch

Does anything help the condition? _____

Does anything worsen the condition?

_____

List any other doctor(s) who have treated you for this condition.

_____

_____

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Consent to Communicate

Patient Name_____

Best way to contact you…

Cell Phone_____

Home Phone_____

Email_____

Regular
Mail_____

_____

Is it okay to leave a message with another person?.....

Name_____ DOB_____Relationship_____

Name_____ DOB_____Relationship_____

Name_____ DOB_____Relationship_____

Signature_____Date_____