BARE FOOT CARE SPECIALIST

3485 Atlanta Highway Flowery Branch, GA 30542
Phone 770-531-9222 Fax 770-531-9020

Patient Information Date _____

Patient Name _____
Last name First Name Middle Initial

Mailing
Address _____
City State Zip

Social Security Number _____ Date of Birth _____

Home Phone (_____)_____ Work Phone (_____)_____

Cell Phone (_____)_____ Email _____

Married__ Widowed__ Single__ Minor__ **(Adult Responsible for the Minor)** _____ DOB: _____

In case of an emergency, contact: Name _____ Phone (_____)_____

RELATIONSHIP TO THE PATIENT: _____

Insurance Information

Name of **1ry Insurance** _____ **2ry Insurance** _____

Who is responsible for **the patient's** account? Same as above: YES __ NO___ IF A MINOR, PLEASE INDICATE ADULT RESPONSIBLE ABOVE.

If no, indicate **NAME OF POLICY HOLDER:** _____ **Social Security #:** _____

A COPY OF YOUR CURRENT INSURANCE CARD(S) WILL BE SAVED AS PART OF YOUR FILE AND WILL BE USED TO BILL YOUR INSURANCE COMPANY(IES) FOR ANY COVERED MEDICAL SERVICES.

All Insurance Assignment and Release (REQUIRED). Please initial all that apply and sign at the bottom.

I certify that I have insurance coverage with the above listed insurance(s) and assign directly Bare Foot Care Specialists, all insurance benefits, if any, otherwise payable to me for services rendered. I authorize release to the indicated insurance company(ies) any medical information needed to determine these payments for related services. _____ initial

I hereby agree to pay Bare Foot Care Specialists, in a timely fashion, for any and all services rendered which may or may not be covered by my insurance. This includes any co-payment, deductible and/or insurance payments that I may receive as a result of services rendered. **Should my account not be paid in a timely manner I understand that I will be held responsible for any further collection and/or attorney fees.** An additional fee of $25.00 will be imposed in the event of a returned check for insufficient funds. _____ initial

In the event that my medical insurance **is terminated, changed, cancelled, or reinstated** after the date when services were provided, I understand and certify that I will be responsible for the **entire cost** of the medical expenses that are billed to my insurance company. I understand that I will then be responsible for contacting my insurance company and attempt to be compensated for all or any of the cost of my medical care, previously or currently being denied for lack of coverage. _____ initial

_____ _____ _____
Signature of Patient, Parent or Guardian Print name of Patient, Parent or Guardian Date

PLEASE ANSWER ALL THE QUESTIONS BELOW

Podiatric/Medical History

What is the main reason for which you came to be treated? (include specific condition of foot, ankle, knee, thigh, and hip complaints)

_____

Is there any ***personal*** or ***family history*** of **diabetes**? _____ Yes _____ No **WHO?**_____

List any **other medical problems in the family**: _____

Women Only – Are you currently pregnant? _____ Yes _____ No If **Pre/Diabetic,** what was your last AIC results? _____

Athletic activities in which you participate (please list and indicate frequency) _____

_____

Please circle any foot/ankle problems you have now or have had in the past.

Ankle Pain Athlete's Foot Bunions Corns/Calluses Cramps/Numbness in Foot/Legs Flat Feet Foot Ulcers Fractures (Foot/Ankle) Gout Hammertoes Heel Pain Ingrown Toenails Nail Fungus Neuromas Plantar Warts Swelling in Ankles/Feet Skin cancer Tired Feet

NAME OF YOUR MEDICAL DOCTOR/PRIMARY CARE PHYSICIAN: _____ PHONE #: (____)_____

DATE of LAST VISIT TO YOUR MD/PCP: _____ ***WHO REFERRED YOU TO US?*** _____

Mark (x) If you currently have or have had in the past any of the following:

AIDS___ Appendicitis___ Arthritis___ Asthma___ Bleeding Disorders___ Blood Clots___ Breast Lump___ Cancer___ Cataracts___ Chicken Pox___ Chemical Dependency___ Circulation Problem___ Diabetes___ Emphysema___ Epilepsy___ Glaucoma___ Heart Disease___ Hepatitis___ Herpes___ High Blood Pressure ___ High Cholesterol___ HIV positive___ Kidney Disease___ Liver Disease___ Measles___ Migraine Headaches___ Multiple Sclerosis___ Mumps___ Neuropathy___ Pacemaker___ Pneumonia___ Polio___ Prostate Problem___ Rheumatic Fever___ Scarlet Fever___ Stroke___ Thyroid Problems___ Transplants___ Tuberculosis___ Ulcers___ Venereal Disease___

Other Medical Problems which you have or have had: _____

_____

Surgeries

Please list all previous surgeries: _____

_____

_____

***ALLERGIES to medications or substances:** _____

_____

Medications & Dosages

List all medications you are currently taking:_____

_____

PHARMACY (LOCAL) you use: _____ CITY_____ Phone (____)_____-_____

Health Habits

Mark (x) which you use and how often:

___ Caffeine _____

___ Tobacco/Cigarette _____ (packs/day)_____

___ Street Drugs _____

___ Alcohol _____

Mark (x) if your work exposes you to:

___ Stress

___ Heavy Lifting

___ Hazardous Substances

___ Other _____

Your Occupation _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor, ever have a change in health.

_____ _____ _____

Signature of Patient, Parent or Guardian Relationship Date

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, AND TREATMENT CONSENT.

Health and accident insurance policies are a contractual arrangement between an insurance carrier and the insured. It is the responsibility of the insured to verify eligibility for health care benefits. Possession of a medical insurance member ID card is **NOT** a guarantee of coverage. As a courtesy to you, we will gladly submit your medical bills to your insurance carrier.

1. **Primary Insurance:** I request that payment of authorized benefits be made on my behalf to **Bare Foot Care Specialist** for services furnished to me by **Bare Foot Care Specialist.** I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. **Bare Foot Care Specialist** accepts the charge determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance, co-pays, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the carrier and are due at the time of service. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to **Bare Foot Care Specialist. As a courtesy, Bare Foot Care Specialist will file your insurance for you, however, by signing below you are stating that you understand that you as the patient are ultimately responsible for payment for services rendered.**
2. **Secondary Insurance:** I request that payment of authorized secondary insurance benefits be made on my behalf to **Bare Foot Care Specialist** if possible or otherwise to me, at which time I would forward all payments to **Bare Foot Care Specialist.**
3. **Release of Information: Bare Foot Care Specialist** may disclose all or any part of my medical record and/or financial ledger to any person or corporation (1) which is or may be liable or under contract with **Bare Foot Care Specialist** for reimbursement for services rendered and (2) any health care provider for continued patient care. **Bare Foot Care Specialist** may also disclose, on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statutes, or regulation.
4. **Non-Covered Services:** I understand that **Bare Foot Care Specialist** contracts with health insurance plans. Accordingly, the undersigned accepts full financial responsibility for all items and services which are determined by the health care insurance plan as non-covered services.
5. **Financial Agreement:** I agree that in return for the services provided to me by **Bare Foot Care Specialist** I will pay my account at the time service is rendered or will make financial arrangements satisfactory to **Bare Foot Care Specialist** for payment. **If my account is sent to collections, I agree to pay an additional 35% for collection fees.** I understand and agree that if my account is delinquent, I may be charged a service fee. It is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill. Furthermore, by signing below I acknowledge that I have been made aware that there is a $25.00 fee for all returned checks and a **$85.00 fee for any missed appointments** where *proper* notice is not given. **The parent/legal guardian bringing the child to our facility will be responsible for required co-payments, deductibles, etc., at the time of service.**
6. **Privacy Plan:** I agree that I have been given the opportunity to read and receive a copy of **Bare Foot Care Specialist's Notice of Privacy Practices.**
7. **Notice:** Anyone under the age of 18 will not be seen without a parent or guardian present unless you are an emancipated minor.
8. **Treatment Consent:** By signing below I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me, as the doctor deems necessary in the diagnosis and/or treatment of my feet and/or ankles.
9. **Additional Disclosure Authority:** Please indicate any additional parties we are allowed to speak with regarding your account (please circle):
   - **Spouse?** Name_____ **YES NO** **Immediate Family? YES NO**
   - **Other?** Name_____ **YES NO**
   - **Can we leave a message regarding your health information on your answering machine? YES NO**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

_____ _____

Signature of Patient, Guardian or Representative **Date**

_____ _____

Please Print Name **Relationship to Patient**

_____

Birth Date of Person signing

BARE FOOT CARE SPECIALIST, LLC
Podiatric Medicine & Surgery
3485 Atlanta Highway
Flowery Branch, GA. 30542
PHONE NUMBER: 770-531-9222
FAX NUMBER: 770-531-9020

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information (Please Print):

Name:_____ Date:_____

SSN:_____ Date of Birth:_____

Address:_____

City:_____ State: _____ Zip:_____

Phone: _____

Please release my medical information to:

Bare Foot Care Specialist, office of Dr. Jeannette Velazquez.

By signing this form, I am authorizing a release of my medical records to the office mention above.

_____ _____
(Signature) (Date)