Registration Information:

Patient Name:_____ Date of Birth:_____

Guardian's name (if patient is under 18 or unable to sign own consent: _____

Address:_____
(Street) (City) (State) (Zip)
Primary Phone # :_____ Secondary Phone #:_____

Email Address:_____

Sex (please check one): ____M ____F Age:____

Information Below Required by Medicare:

Race: (Please Check One):

__American Indian or Alaskan Native __Black or African American __White

__Asian __Native Hawaiian or Other Pacific Islander __Other

Preferred Language (Please Circle One):

English/Spanish/Other:_____

Ethnicity (please Circle One):

Cuban/ Hispanic or Latino/ Mexican/ Puerto Rican/ Not Hispanic or Latino

Emergency Contact Name:_____ Phone #:_____

Referring/Primary Care Physician:_____ Phone #:_____

How did you learn about our office: _____

If you have Diabetes (please check one): _____ Type I_____ Type II What was your last A1C value _____?

Doctor who is managing your diabetes:_____ Phone #:_____

Do you have a Family History of Diabetes? (Please check one) ____YES ____NO _____ Mother _____ Father _____ Sibling

Insurance Information:

Insurance Company:_____

Subscriber Name:_____ Date of Birth:_____

Relationship to Patient:_____

Group Number:_____

Podiatric History:

What is your chief complaint? (Include which foot/ankle?):_____

_____

_____

_____

Have you been treated by a podiatrist before? ____YES ____NO

- If Yes, Please List:
  - Name:_____ Last Visit:_____

Your Occupation:_____

Cigarette/Tobacco Use (Please Check One): ____YES ____NO ____FORMER

- If Yes:
  - How many years?____
  - Packs/Day?_____

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

Medical History:

Please list any diagnosed conditions:

Medications: Please List all Medications you are currently taking including OTC/Vitamins:

List Allergies to Medications: ___ __No Known Allergies

ALLERGY:	**REACTION:**

Surgical History:

List surgeries:

SURGERY:	DATE:

Consent for Treatment

I the undersigned, authorize Dr. Eric Diamond to examine and treat my feet medically or surgically. I hereby assign my insurance benefits to be paid directly to Chesapeake Podiatry Group and I am responsible for any unpaid balance. I authorize the release of any medical information necessary to process all claims.

SIGNATURE: _____ DATE: _____

GUARDIAN'S SIGNATURE: _____ RELATION: _____DATE: _____
(IF PATIENT IS A MINOR OR UNABLE TO SIGN OWN CONSENT)

Authorization to Discuss Confidential Medical Information

This form is **optional**. Please only complete this section if you would like to authorize Dr. Eric Diamond to discuss your confidential medical information with anyone other than yourself.

I, _____ give full authorization to discuss my medical treatment, medications, diagnosis, and/or financial information with the following parties only. I understand that my medical care will not be discussed with anyone that is not on this list.

Name:	Relation:

Financial Policy Insured Patients

Thank you for choosing our office for your foot and ankle needs. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. **A copy will be provided to you upon request.**

- **Insurance.** We participate in most insurance plans, including Medicare. Always bring your insurance card with you when you come in for a visit. If you are not insured by a plan we do business with, payment is expected at each visit. If you are insured by a plane we do business, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.
- **Co-payments and deductibles.** All co-payments are due at the time of service. If your insurance plan has a deductible, you are responsible for balance of bill after your insurance claim has been processed.
- **Acceptable forms of payment.** We accept cash, check, money order, Visa, MasterCard, AMEX and Discover. A fee of $35 will be assessed for each personal check returned by your bank as **non-sufficient funds.**

- **Referrals.** It is your responsibility to know whether your insurance carrier requires a referral and to bring it with you at the time of service. If you don't bring a need referral, we will ask you to sign a Referral Waiver if you want to receive services that day. If you are not able to supply a referral from your primary care physician within five business days, you will be responsible for full payment for the service.
- **Non-covered services.** Please be aware that some and perhaps all of the services you receive may be **non-covered or not considered reasonable or necessary** by your insurance company. The fact that the insurance company doesn't cover the service doesn't mean you don't need it. Your doctor will explain why he or she thinks that you can benefit from a service or procedure. If you elect to have the non-covered service, you must pay at the time of visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- **Medicare patients**: If we believe you are receiving a service that Medicare considers not reasonable or necessary for your condition, you will be notified in writing on a form called an Advance Beneficiary Notice of Non-coverage (ABN). This will provide you the opportunity to decide if you will proceed with the service ordered. This process is required by Medicare and preserves your right to appeal their decision.
- **Coverage changes.** If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
- **Claims submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company May need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
- **Nonpayment**. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be assessed a 35% surcharge to cover agency fees. You will receive a statement of your account each month and may receive a telephone call or certified letter about unpaid balances. If your account is over 90 days past due, the message on your statement will say that your account is being reviewed for placement with a collection agency and you have 10 days to send payment in full. Partial payment will not be accepted unless otherwise negotiated with the billing office. Extended payments need to be discussed with the billing office at 410-363-2233.
- **Missed appointment**. We reserve the right to charge for missed appointments and those that are canceled within 24 hours of the date of the appointment. Our fee is $50.00. These charges will be your responsibility and will be billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment or canceling with us at least 24 hour in advance.
- **Forms Completion**. We reserve the right to charge for completion of forms (disability, MVA, etc.) because it requires time and resources that are in scarce supply. Our fee for simple forms, single page form is $10.00 each. Our fee for complex, multi-page forms is $25 each. Fees must be paid in full at the time your request to fill out these forms is made.
- **Medical Records.** Your medical records will be provided to other providers and your insurance carrier without charge. If medical records are needed by others, such as attorneys, there will be a service charge for printing or copying and mailing.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. If you have any questions or concerns, please contact our **billing office at 410-363-2233**. Representatives are available to assist you **Monday through Thursday from 8:30 as until 4:00 pm.**

All payments and correspondence should be mailed to:

Chesapeake Podiatry Group
25 Crossroads Drive #410
Owings Mills, MD 21117

I have read and understand the Chesapeake Podiatry Group Financial Policy and agree to abide by it guidelines:

SIGNATURE: _____ DATE: _____

GUARDIAN'S SIGNATURE: _____ RELATION: _____DATE:_____
(IF PATIENT IS A MINOR OR UNABLE TO SIGN OWN CONSENT)