

AGAPE PODIATRY PATIENT REGISTRATION FORM

Personal Information

Name: _____ Home Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Work Phone #: _____

Age: _____ Sex: _____ Date of Birth: _____ SSN: _____

May we contact your home and leave a message with other residents?? (YES) (NO) IF yes, who are we authorized to leave messages with?? _____

May we leave messages on your answering machine or home voice maim (YES) (NO)

Do you have an email address? _____

May we send and receive information with you via the internet (YES) (NO)

Financial Responsibility

Are you responsible for yourself financially (YES) (NO). If not please indicate the responsible party on the lines below including the following information: **name, address, phone number, social security number, and birth date**

Relationship to patient: _____

May we talk to this person about your medical concerns?? (YES) (NO)

Is this visit in response to a current or pending workers comp injury (YES) (NO)

Date of Occurrence: _____ Claim#: _____

Has an accident report been filed by your company (YES) (NO)

Company Name: Address: _____

Phone #: _____ Fax#: _____

Primary Insurance Company: _____ Name on Contract: _____

Relationship to Card Holder: _____ Co Payment: _____

Secondary Insurance Company: _____ Name on Contract: _____

PLEASE PROVIDE ALL YOUR INSURANCE CARDS AT THIS TIME FOR COPYING

Cards Copied (YES) (NO)

MEDICAL INFORMATION

Who may we contact in the event of a Medical Emergency? _____

Home Phone #: _____ Work Phone#: _____

Primary Care Physician: _____ Phone #: _____

May we provide your Physician with updated information periodically? (YES) (NO)

Are you currently seeing a specialist for an ongoing specific condition (YES) (NO)

If so, which specialist are you seeing? _____

Specialty: _____ Phone #: _____

Were you referred to our office by another physician (YES) (NO)

Who may we thank for referring you? _____

Please read the following information concerning your financial responsibility and sign below

1. For all patients with HMO, MC, or PPO Insurance: It is the patients responsibility to obtain the proper referrals from your Primary Care Physician prior to your visit so that you can receive the maximum benefit from your insurance for services. Back referrals are no longer accepted practice by many physicians' offices and insurance companies. Check with your insurance company to make sure that our practice is in your **network**.

I agree to pay all charges in the event that a proper referral is not obtained:

2. For our patients with **Medicaid**: It is your responsibility to present your card at **each visit** to verify your continued eligibility.
3. For all our **Medicare** patients: We are a participating practice with **Medicare**, which means, we will accept the amount that Medicare approves for our services. Medicare pays **80%** of their established rate for services. You as the patient are responsible for the remaining 20% of the fees either through secondary insurance or self- payments. Medicare also has a standard \$100.00 deductible each year that must be met before payment of services is rendered.
4. If your insurance plan has standard **co-pay**, you will be expected to make payment at the time of your visit.
5. Accepted methods of payment are **cash, personal check, or credit card (We accept MasterCard, Visa, and Discover)**

AGAPE PODIATRY is required to process your insurance claims with your primary insurance carrier. We will bill any secondary insurance as a professional courtesy to you, the patient. Please let us help you to receive the maximum benefit from your insurance companies. Have a current copy of your insurance cards handy so that we may keep a copy of them in your records. If you change insurance companies during the course of your treatment, please provide us with the updated information promptly. If you have any questions about our insurance policy, feel free to ask them at the time of your visit, or call us during normal business hours.

It is our policy to bill your insurance companies for reimbursement, However we shall allow no more than sixty (60) days for payment. After sixty (60) days, you will be billed for any outstanding balances on your account. We will be more than happy to help you with any problems you may have with your insurance companies by providing any needed information they require, but you **as the patient** are responsible for any problems you have with **your insurance company**. All outstanding balances are due thirty (30) days from the statement date. We reserve the right to charge **1.5% interest** on any outstanding balances after 30 days as well as any collection fees incurred in receiving payment. If you are having financial difficulties, arrangements can be made for any outstanding balances and payment plans are available. Please call the office during regular business hours, or stop in to discuss your billing options.

I have read and understand the above statements and I directly assign all medical and surgical benefits to the doctor. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor to release all information necessary to secure payment of my benefits

Signed: _____ Date: _____

PRIVACY AND CONSENT INFORMATION

"This consent form is required by the Health Insurance Portability and Accountability act of 1996 (HIPAA) which requires us by law to inform you of your rights for privacy with respect to the disclosure of your health care information. (Please read and sign below)

I hereby give my consent to AGAPE Podiatry to use and disclose my protected health information for the purpose of treatment, payment and operations of my health care and this practice.

Consent for treatment: I authorize Agape Podiatry and any employee working under the direction of my physician to provide medical care for me or to the patient which I am legally responsible for. This medical care may include services and supplies related to my health (or the identified person) and may include (but not be limited to) preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical and mental status/function of the body and the sale or dispensing of drugs, devices, or other items required in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for the Release of Information for Payment and Operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the Privacy Practice Notice.

Consent Related to the Privacy Notice: I have had an opportunity to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Practice Notice may change and I may obtain these revised notices at any time by contacting them by phone, fax, email, or in writing. I have the right to request information on how my protected health information has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to abide by my requested restrictions, then this practice is bound by that agreement. All requests for disclosure and/ or restriction must be made in writing for documentation purposes. .

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at this time as well. If I revoke this consent, the revocation does not go into effect until this practice receives documented notification (i.e. phone call, in writing, etc.)

Patient/ Guardian: _____ Date: _____

Name Printed: _____ Relationship: _____

Copy of Practice Privacy Policy reviewed and signed on: _____

Patient unable to sign privacy statement due to: _____

Revocation

I Hereby Revoke the Consent Given Above:

Patient/ Guardian: _____ Date: _____

Name Printed: _____ Relationship: _____

Consent for Assignment of Benefits: I consent to assign all payment for these services to this practice. I understand that I am responsible for all co- payments, amounts applicable to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations. I further understand that my contract with my insurance entity may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all the charges that are ensued.

Patient/ Guardian: _____ Date: _____

Agape Podiatry Practice Privacy Statement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

I. **This is a formal notification, as required by the government concerning the privacy policy of this practice.** This practice has an obligation to maintain all medical information in the strictest of confidence. Our practice cannot release information without your written consent, including medical records, conversations, reminder calls, test results and other confidential issues. Patient information about health care is identified as "PHI" or protected health information. This new policy requires that you, the patient, identify at the time of registration with us specific information about release of information. **You can change this information at any time with either written notification or verbal notification, followed up in writing.** Changes can only impact the care or information from that point in time forward.

II. Your protected health information (PHI) is a part of your medical care, and can be used or disclosed as follows:

- For your treatment in this practice and other locations while under our immediate care, for your care needs. This may include any foot care evaluation and exam, procedures done related to your needs, medication management, physical therapy, referral for services, diagnostic tests or treatment related to this care. Release of information to family and significant other (husband or wife) can be done only with your permission on the registration form.
- For obtaining payment for treatment with your identified health care program. This would include any documentation related to this care, including history forms, progress notes, pictures and procedure notes. This would include eligibility verification, prior authorization and claim submission.
- For operations of this practice, such as enrolling with insurance programs, hospital privileges, accounting and compliance with federal and state laws and regulations.
- Appointment reminders and health related benefit services only with your consent identified on the registration form.
- Disclosure to your family and friends concerning any related health care information identified on the registration form, which can be modified at any time orally, followed by written consent
- **Consent is not required for emergency care and treatment An emergency is identified as a medical condition that in the judgment of the physician requires information for care on your behalf.**

Certain disclosures can be made without your consent and they are as follows:

- Disclosure required by the government or law enforcement agencies. An example would be victims of abuse
- Information used for public health purposes, medical examiners or related to a person's death or for the health department for disease tracking.
- Information used for health care oversight, such as a site review by an insurance program.
- For worker's compensation cases or employment related assessments

III. Your rights for your health information include: The right to request limits on the uses and disclosure at registration or any time during your care. The right to choose how we send this information to you, including an alternate address. The right to see and obtain copies of your PHI, but there may be copy and postage fees. The right to get a listing of who we have made disclosures to about your PHI. The right to collect your file through an amendment process if appropriate.

IV. This practice reserves the right to modify or change this Privacy Statement and process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice. An updated Privacy Notice will be posted in the office within 60 days of the revision.

V. If you have a concern or complaint about how your protected health information is being used, from this time forward you should first contact our Practice Administrator at our Business office to resolve your concerns or you may contact the Office of Civil Rights or the Ohio Medicare Carrier, GBA Palmetto.

Office of Civil Rights -Regional Manager
Department of Health & Human Services
233 N. Michigan Avenue, Suite 240
Chicago, Illinois 60601

Palmetto GBA
Part B Operations -HIP AA Compliance Concerns
PO Box 18957
Columbus, Ohio 43218

Patient name: _____ DOB: _____

Patient signature on receipt of Privacy Notice: _____ Date: _____

Patient [] unable to sign due to: _____ [] Refused to sign Date: _____