

FAMILY FOOT & LEG CENTER, P.A.  
PATIENT REGISTRATION FORM  
**Identification Policy of Family Foot & Leg Center**

Medicare and our network private insurance companies require us to have on file a copy of your identification card. Acceptable identification is the following: driver license, passport, government ID, military ID.

***You will not be seen without proof of identification.***

(Please fill out each item or put N/A)

\_\_\_\_\_  
Name: MR. MRS. DR. MS. \_\_\_\_\_

Driver License [# and State] **AND** Social Security Number \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home # \_\_\_\_\_

Cell# \_\_\_\_\_ Work # \_\_\_\_\_

Email Address \_\_\_\_\_

Local Address \_\_\_\_\_

Secondary Address \_\_\_\_\_

Insured's Name/Date of Birth/SS# if different from above \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Personal Physician Name \_\_\_\_\_

Physician Address/Phone Number \_\_\_\_\_

Who may we thank for this referral? \_\_\_\_\_

\_\_\_\_\_  
If patient is a minor, name of person responsible for payment \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

\_\_\_\_\_  
I hereby give permission to Dr. Lam, and/or his associates of Family Foot and Leg Center, P.A. to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. I also hereby assign to the above named physicians all benefits provided by my insurance company policy or policies for medical or surgical care. **I understand that I am financially responsible for any balance due on my account and a collection agency will be employed to enforce such.** Furthermore, I have read and signed the financial responsibility form and understand the financial policy of the Family Foot and Leg Center, P.A. This is a lifetime signature.

**Privacy and Information Protection Policy**

Our office utilizes a HIPAA compliant Electronic Medical Record Storage system. All data collected on this form is strictly used for insurance claim purposes and never shared with outside sources. All information not stored in the secured electronic storage format are shredded and disposed of properly. **By signing below, you are acknowledging that you have either received a copy of our Privacy Policy or have been given access to a copy to review.**

It is understood that **all Durable Medical Equipment & products** including, but not limited to, creams, lotions, orthotics, arch supports, braces, pads, diabetic shoes, surgical shoes, crutches, can be purchased via an outside professional vendor. The products and in-office dispensing are for our patients' convenience; **financial responsibility will be solely on the patient.** All payments for such services or devices are due upon the receipt of service or item unless other arrangements have been made in advance.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

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## Podiatric Medical History

THIS IS REQUIRED INFORMATION FOR THIS OFFICE AND MUST BE SUPPLIED

What is your foot or lower leg complaint? \_\_\_\_\_

For how long have you had it? \_\_\_\_\_ Pain level (0 = no pain, 10 = extreme pain) \_\_\_\_\_

What aggravates this? \_\_\_\_\_

What helps this problem? \_\_\_\_\_

More pain -- [ ] in the morning or [ ] end of the day

Have you ever been treated by a podiatrist or orthopedist? [ ] YES [ ] NO

Name and Address \_\_\_\_\_

If yes, list treatments rendered \_\_\_\_\_

**\*\*\* Please Note: IF YOUR VISIT IS DUE TO AN INJURY, BRIEFLY DESCRIBE THE EVENTS SURROUNDING THE OCCURANCE (Where? What activity were you doing? Etc.)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Other Medical Problems

Tobacco (Yes / No) If yes, how many packs per day \_\_\_\_\_; If yes, for how many years \_\_\_\_\_

Alcohol (Yes / No) If yes, how frequent \_\_\_\_\_; Occupation \_\_\_\_\_

**Drug Allergies** \_\_\_\_\_

**Medications** (include herbal and over-the-counter medications) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical Problems (Reason for Taking Medications)** \_\_\_\_\_  
\_\_\_\_\_

Have you ever tested positive for infectious diseases such as Hepatitis or HIV? [ ] Yes [ ] No

**Surgeries** \_\_\_\_\_  
\_\_\_\_\_

**Family History of** [ ] Diabetes [ ] Hypertension [ ] High Cholesterol [ ] Thyroid [ ] Cancer [ ] Other  
\_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**FAMILY FOOT AND LEG CENTER, P.A. - FINANCIAL POLICY**  
**PLEASE SIGN APPROPRIATELY BELOW**

We are committed to providing you with the best possible care. We are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

**Payment for services is required at the time services are rendered.** We accept payment in the form of cash, check, Mastercard or Visa (not AMEX or DISCOVER). If you have insurance coverage that we do not participate with, we will process a claim after you have paid in full any balances due. **Returned checks** are subject to additional collection fees. **Balances older than 90-days are forwarded to a collection agency.**

Please realize that:

1. **MEDICARE PATIENTS:** We would like you to understand that taking assignment means that YOU are responsible for the YEARLY DEDUCTIBLE OF \$131.00 and for the 20% (COINSURANCE) of what Medicare allows. You are also responsible for services that your coinsurance doesn't cover. We may ask you to sign a **Medicare Advanced Beneficiary Form (ABN)**, which states that if Medicare does not cover a service or medical equipment, you understand that you will be responsible for payment.
2. The filing of **SECONDARY INSURANCE CLAIMS** is a COURTESY that we extend to our patients. We will make every effort to help you in the filing of your claims; however, all charges are ultimately YOUR responsibility after the initial filing with your insurance company. We realize that temporary financial problems may affect timely payment of your account. We encourage you to contact us *promptly* for assistance in the management of your account.
3. I agree that **if my account falls delinquent**, I will be responsible for all collection costs, including but not limited to the outstanding balance, attorney fees, court costs, collection agency fees and interest from the date of service at the rate of 1.5% per month [18% per annum].
4. I authorize Family Foot and Leg Center to submit all insurance claims on my behalf. I understand that I am responsible for all services not paid in full within 60 days of service, regardless of the reason given by the insurance company.

Please note:

\*\*\*All accounts must be current (have a \$0.00 balance) before any medical records are released.

\*\*\*There is a \$15.00 charge to the patient for the completion of forms (insurance, disability, etc.).

\*\*\*There is a \$35.00 charge for patients who have an appointment but "no call/no show" 2 times.

**NON-PARTICIPATING AND SELF-PAY STATUS - SIGN BELOW**

We are not participating with every insurance company available. If you are not sure if we are participating, we encourage you to call your insurance company to verify our participation. **Ultimately, it is your responsibility to know your policy.** For insurance companies that list us as non-participating or non-preferred providers, **our office policy is to collect the full price of the visit up front.** We will extend the courtesy of filing with your insurance on your behalf after payment of all services rendered. **Any questions about pricing should be addressed *prior* to treatments being rendered.**

Signature and Date \_\_\_\_\_ Date \_\_\_\_\_

**PARTICIPATING INSURANCES AND MEDICARE ASSIGNMENT -- SIGN BELOW**

I authorize payment of MEDICAL BENEFITS be made on my behalf to Family Foot and Leg Center, P.A., for any services furnished to me. I authorize the release of any medical information held by the Family Foot and Leg Center, P.A. to the health care financing administration and its agents in order to process my claims.

Signature and Date \_\_\_\_\_ Date \_\_\_\_\_

**POLICY ON MEDICAID (FOR MEDICAID PATIENTS ONLY) - SIGN BELOW**

We participate on a *limited* basis with Florida Medicaid. **All Medicaid patients will be treated as self-pay patients *except* as secondary payer to Medicare, children 17 years old or younger or if seen as a first time patient in the hospital.**

Signature and Date \_\_\_\_\_ Date \_\_\_\_\_



## AUTHORIZATION TO SHARE "PROTECTED HEALTH INFORMATION" (P.H.I.)

PURPOSE: To permit Family Foot and Leg Center to share personal health information with persons other than the patient's name below:

**Section I:** [Please print]

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_

**Section II:** Please identify the person(s) with whom your information may be shared and their relationship with you. Please print.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

**Section III:** This authorization will expire *only* upon receiving written notification from me.

**Acknowledgement:** I, hereby, permit Family Foot and Leg Center to share the following "protected health information" concerning me:

- Health information concerning appointments; all past, present, and future health information
- Any and all laboratory results and other diagnostic results (e.g., x-ray, bone scan, ultrasound, etc.)
- Confirmation of appointment details

I understand that my "protected health information" may be shared with the people listed and that they may not be required to comply with federal health information privacy laws. I understand that the practice reserves the right to deny access. In addition, authorized individual (s) must present identification as proof that they are who they claim to be.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date