GULF COAST PODIATRY

Joseph E. Kiefer, DPM

Specializing in
Medicine and Surgery of the Foot

1851 North Ninth Avenue
Pensacola, Florida 32503
(850) 434-9867
(850) 434-9878 Fax

Date _____

Name (First)_____ (Last) _____ ❑ male ❑ female

Address _____ Apt# _____

City _____ State _____ Zip _____

Birth Date_____ Age _____ Social Security # _____-_____-_____

Home Phone_____ Work Phone_____

E-Mail _____ Cell Phone _____

Marital Status: ❑ Single ❑ Married ❑ Widow ❑ Divorced

Place of Employment _____ Occupation: _____

Preferred Language_____ Ethnicity _____Race _____

Spouse's Name_____ Contact #_____

PERSON RESPONSIBLE FOR BILL

Name_____ Relationship_____

Address_____ Phone #_____

Employer_____ Position_____

Employer's Address _____ Phone #_____

INSURANCE INFORMATION

Subscriber's DOB: _____

COMPANY OR PROGRAM INSURED SS# GROUP # POLICY #

1._____

2._____

3._____

EMERGENCY CONTACT INFORMATION

Name_____ Relationship_____

Address_____ Phone#_____

Employer _____ Position_____

OUR PATIENT FINANCIAL POLICY

Thank you for choosing Gulf Coast Podiatry to serve your healthcare needs. We are committed to your successful treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment. Our practice firmly believes that a good physician and patient relationship is based upon understanding and good communication. We believe that an informed patient is a more satisfied patient. Therefore, we want to communicate our Patient Financial Policy to you in writing so that you will know what to expect at the time of your visit.

Insurance

All patients must complete our patient information form and provide current information before being seen by the doctor. We accept assignment from many insurance companies, but in the event that your insurance does not cover your visit or treatment within a reasonable time (45-60 days) the balance may automatically be transferred to the patient's responsibility. Please be aware that some of the services provided may be non-covered services and considered not reasonable and necessary under Medicare and/or other medical insurance guidelines.

You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

We must emphasize that **our relationship is with you, not your insurance company**. We will appeal disputed claims with insurance companies to the extent additional documentation is required from us in order for your claim to be processed. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of what those rates should be.

All co-pays, deductible, and balances owed are due at time of service. Your appointment may be rescheduled if you are unable to pay and prior arrangements were not made in advance.

If your insurance applies any of your charge to your annual deductible or coinsurance, that portion is due and payable by you at the time of service. If you have elected to use our services out of your network of coverage please check with your insurance regarding benefit levels. Your employer or provider of insurance determines your benefit coverage by contracting with a particular insurance company. If you have questions regarding your coverage, please speak with your human resources representative or use the payer web address listed on your card. **It is your responsibility to understand your benefit coverage.**

***** THIS OFFICE DOES NOT HAVE A CONTRACT WITH ANY FORM OF MEDICAID OR WORKERS COMPENSATION*****

High Deductible Health Plans (HSA, HRA, FSA participants)

Please inform us prior to your visit if you are a participant in a High Deductible Health Plan (HDHP), a Health Savings Account (HSA), a Health Reimbursement Arrangement (HRA) or a Flexible Spending Account (FSA). You must be prepared with the plan information and pay the patient responsible portion from the HSA, HRA or FSA **at the time of service.**

Patient Responsibility

If you are seeking a *non-covered service, do not have insurance, or if you are a participant in an insurance for which we are not a provider*, we require that you be prepared to pay our fees at the time services are rendered. Please inquire with our staff about our prompt pay discount policy. If you are covered by insurance your bill will be reduced to our contracted allowable amount.

Any appliances dispensed to you from this office are final sale and non-refundable. By signing this form, you understand that you will be responsible for all portions not covered or not paid by your insurance company. It is your responsibility to ensure that all appliances, including but not limited to: cam walkers, braces, shoes, night splints and orthotic devices are authorized before dispensed to you. *Once these items leave the office they may not be returned and you are responsible for payment.*

Payment Details

We accept cash, check and most major credit/debit cards. We have the capability to accept payments over the phone with your debit or credit account information. We reserve the right to process your payment electronically based on information you provide to us.

If you are having surgery, the surgery center and anesthesiologist are separate providers from us. Payment for services performed at any facility outside our office needs to be discussed with that facility.

There is a service fee of $35.00 for all returned checks.

Account Delinquency and Credit Reporting

An account is considered delinquent and may be referred for collections if payment in full is not made in a timely manner. If you are unable to adhere to an original payment agreement you must contact us to discuss alternative arrangements. If payment arrangements are not made and/or payment in full is not made, your account with us would be referred to collections, and your credit history may be obtained. We also reserve the right to bill a collections fee in addition to the outstanding amounts owed for services rendered. All outstanding balances must be paid off in order for future visits to be scheduled. If not resolved in a timely manner, we reserve the right to dismiss you from our practice.

Minor Aged Patients

The parent or guardian accompanying the minor is responsible for payment of any fees for that minor not covered by insurance. For unaccompanied minors, treatment will be denied unless we have received the proper paperwork. Insurance cards need to list the minor's name.

Missed Appointments

Appointment times are extremely valuable to our patients. We require a 24 hour notification If you need to cancel or reschedule an appointment. Though we understand that there are unforeseen circumstances, ***we reserve the right to charge a fee of $25 if you do not show up or cancel your appointment without a 24 hour notice.*** *Reminder calls are a courtesy and it is the patient's responsibility to know when their appointment is.*

I have read the Financial Policy. I understand and agree to this Financial Policy.

Name of Patient or Guarantor: _____

Signature: _____

Date: _____

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

1. Release of information: The physician may disclose all or any part of the patient record to any person or corporation which is, or may be liable under contract to the physician or the patient or a family member or employer of the patient, for all or part of the physician's charge, including but not limited to, insurance companies, worker compensation carriers, and welfare funds. The physician may also send copies of all of the patient's records to any physician that participates in the total medical care of the patient.

2. Assignment of insurance benefits: In the event the patient is entitled to physician benefits arising out of any policy of insurance insuring patient or any other party liable to patient, said benefits are hereby assigned to the physician for application on patient's bill, and it is agreed the physician upon receipt of such benefits, shall discharge the said insurance company of any and all obligation under the policy to the extent of such payment and the undersigned and/or patient shall be responsible for all charges not covered by this assignment.

3. Medicare: I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize the release of all my records required to act on this request and that payment of authorized benefits be made directly to the physicians involved in my care and for any services furnished to me requested by said physician.

I UNDERSTAND ALL OF THE ABOVE AND HEREBY STATE THAT THE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____

Patient Signature Date

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I understand the US Department of Health and Human Service's Health Insurance Portability and Accountability Act of 1996 (HIPAA) and that I may request a copy and the opportunity to read it*.

_____ _____

Patient Name (Print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

I give my permission to release my medical information to the following individual(s):

_____ _____

Name Date

_____ _____

Name Date

*available in office

MEDICAL HISTORY

Patient Name_____ Date_____

Primary Care Physician_____ Date Last Seen_____

Diabetic Physician_____ Date Last Seen_____

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

If so, by whom_____Date Last Seen _____

ALLERGIES to Medication Penicillin Sulfa Cortisone Novocain Codeine
Other_____

Are you diabetic? ❑ YES ❑ NO Date you were diagnosed? _____ Do you take insulin? ❑ YES ❑ NO

Have you ever experienced? Heart Attack Stroke Heart Bypass Leg Bypass Phlebitis/DVT

Have you ever been diagnosed or treated for the any of the following? (circle all that apply)

Allergies	Circulation Disorder	Heart Murmur	Neuropathy
Arthritis	Chronic Back Pain	Hearing Loss	Skin Disorders
Anemia	Gout	High Blood Pressure	Thyroid Problems
Asthma	Hay Fever	Kidney Disease	Varicose Veins
Cancer	Headaches	Leg Cramps/Pain	Vision Problems
	Heart Disease	Liver Disease	Ulcers

Other:_____

Have you been diagnosed with Hepatitis, AIDS or any other communicable diseases: ❑ YES ❑ NO

Are you pregnant? ❑ YES ❑ NO
Do you use tobacco? Never previously, but quit Current _____packs a day
Drink alcohol? Never Socially Moderate Regularly
Drink coffee/tea? ❑ YES ❑ NO Cups per day?_____

Do you have a family history of any of the following: (circle all that apply)

Arthritis	Gout	Kidney Disease	Thyroid Disease
Cancer	High Blood Pressure	Sickle Cell Disease	
Diabetes	Heart Disease	Stroke	

Reason for Today's Visit: _____

_____

_____

Problem(s) involve: Nails Toes Arch Heel Ball of Foot Ankle Leg

Duration of problem: ____Days ____Weeks _____Months _____Years

LIST OF ALL MEDICATIONS CURRENTLY TAKING:

Name of Medication: MG or UNITS DOSE

LIST ALL PREVIOUS SURGERIES AND YEAR PREFORMED