# *Foot Doctor*

Cottage Hill Podiatry Group, PC

*Elliot Jay Braun*, DPM, DABLES, DAAPM, FAAFAS

1371 Montlimar Drive

Mobile, Alabama 36609

251-304-0804

## PATIENT INFORMATION

*Please Print All Information*

Name: _____ (LAST) _____ (FIRST) _____ (MIDDLE)

Mailing Address _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Home Phone (____) _____ Work Phone (____) _____ Cell Phone(____)_____

E-Mail Address:_____

Sex (Male/Female) _____Age _____Birth Date _____/ _____/ _____

Employer's Name _____ Address_____ Phone(____) _____

**NOTE: *The Federal Government requests* that we ask the following:**

**Race:** White ____Black_____ Asian _____ Hispanic _____American Indian_____ Other_____

Preferred Language_____

Marital Status: _____ (Single, Married, Widowed, Divorced) Spouse's Name _____ Spouse's Birth Date _____/_____/ _____

Spouse Employer's Name _____ Address _____ Phone(____) _____

***If Patient is a Minor, List Parent's or Legal Guardian's Name*** _____

In Case of **EMERGENCY** Call: Name_____ Phone(_____) _____

Family Physician_____Date of Last Visit_____

## INSURANCE

***NOTE:*** Please bring ***ALL*** your insurance cards with you to our office. We will make copies for your file.

**Insurance Holder**

Name _____ Birth Date _____/_____/_____

Address_____ (STREET) (CITY) (STATE) (ZIP) Phone (____)_____

**Insurance Company - Primary**

**Name of Primary** _____

Policy Number_____

Group Number _____

**Insurance Company - Secondary**

**Name of Primary** _____

Policy Number_____

Group Number _____

**READ CAREFULLY:** *I accept the ultimate responsibility for the payment of fees to the Doctor, unless other written agreements have been made.*

*Signature of Responsible Party*_____

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**Office Use Only:**

Height_____

Weight_____

Blood Pressure_____ / _____

Pulse _____

Shoe Size _____

## CURRENT MEDICAL HISTORY

**PREVIOUS SURGERIES AND HOSPITALIZATIONS:** *Please list all Surgeries and Hospitalizations, including dates and reasons.*

1. _____

2. _____

3. _____

4. _____

**FAMILY HISTORY:** *(Check all that apply)*

Does any close relative have:

____ Diabetes

____ Hypertension

____ Heart Condition

____ Arthritis

____ Chronic or Genetic Disease

**SOCIAL HISTORY:** *(Check all that apply)*

____ Do You Smoke? How Much? _____

____ Have You Ever Smoked? When did you quit? _____

____ Do you Drink? How Much? _____

____ Do you Exercise? Sports Activities _____

_____

_____

**ALLERGIES:** *(Check all that apply)*

____ Codeine ____ Adhesive tape

____ Keflex ____ Local anesthesia

____ Penicillin ____ Mycin type drugs

____ Sulfur ____ Iodine

____ Others: _____

_____

**MEDICATIONS**

*Please list all medications you are currently taking:* _____

_____

_____

_____

_____

*Are You On A Blood Thinner?* _____

Name of Your Family Physician: _____ Date of Last Visit _____

Your Pharmacy: Name _____

Address/Location _____ Phone _____

_____ **Are You Pregnant?** *(Yes/No)*

**PLACE A CHECK MARK NEXT TO ANYTHING THAT APPLIES TO YOUR HEALTH**

**HEENT:**
- ____ Headaches
- ____ Vision Problems
- ____ Glaucoma
- ____ Cataracts
- ____ Hearing Loss
- ____ Sinus Problems
- ____ Vertigo

**CARDIOVASCULAR:**
- ____ Hypertension
- ____ Angina
- ____ Heart Attack
- ____ Open Heart Surgery
- ____ Arrhythmia
- ____ Mitral Valve prolapse
- ____ Angioplasty
- ____ High Cholesterol/Triglycerides

**SKIN & INTEGUMENTARY:**
- ____ Rash
- ____ Contact Dermatitis
- ____ Moles
- ____ Fungus Nails
- ____ Warts
- ____ Eczema/Psoriasis
- ____ Ulcers

**ENDOCRINE:**
- ____ Diabetes-*Insulin Dependent*
- ____ Diabetes-*Non-Insulin Dependent*
- ____ Thyroid
- ____ Osteoporosis

**GASTROINTESTINAL:**
- ____ Ulcers
- ____ Gall Bladder
- ____ Hepatitis
- ____ Diverticulitis
- ____ Reflux
- ____ Cirrhosis

**NEUROLOGICAL:**
- ____ Seizures
- ____ Stroke/TIA
- ____ Alzheimer's
- ____ Back Problems
- ____ Parkinsonism

**RENAL:**
- ____ Kidney Stones
- ____ Kidney Failure
- ____ Chronic Bladder Infection(s)
- ____ Dialysis

**RESPIRATORY:**
- ____ Asthma
- ____ Emphysema
- ____ Breathing Problems

**IMMUNOLOGICAL:**
- ____ Chronic Fatigue Syndrome
- ____ Fibromyalgia
- ____ HIV or AIDS

**MUSCULOSKELETAL:**
- ____ Degenerative Arthritis
- ____ Rheumatoid Arthritis
- ____ Instability

**CANCER:** *Please List* _____

_____

*What is Your Problem? Why Are You Seeing the Doctor Today?* _____

_____

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# The Financial Policy of Cottage Hill Podiatry Group, PC

Cottage Hill Podiatry Group, PC, Dr. Elliot Braun and his staff welcome you to our Medical Office. Prior to your visit with the doctor and our staff we feel ***you*** our patient should be extended the courtesy of being explained the financial policy, including the procedures of billing, insurance filing and collections. Medicine today as in the past is a business and in order to provide the most up to date and the highest quality of medical care to our patients it is essential that our fees must be charged and collected. NOTE: The fees charged are the **usual and customary fees DEVELOPED AND ESTABLISHED by Medicare and Blue Cross of Alabama and not created by our office.**

*Non-Insured Patients:* Please be advised that the fees are the same as the insured patients, but unlike insured patients payment is expected in full at the time of the service, unless a written payment plan schedule (CONTRACT), is agreed to by our accounting department PRIOR to meeting with the doctor.

*Medical Insurance:* If you are covered by third party insurance (Medical Insurance) please show your Identification Card to our Business Secretary, who will make a copy of it. If you have multiple insurers we will file your coinsurance to help increase your reimbursement. We have the computer equipment and the necessary training to assist you in filing your insurance claim. This is done as a courtesy for our patients. Therefore, it is important that you fill out the necessary information on ALL the forms given to you on your first visit with us.

***NOTE:* WE WILL NOT RENDER SERVICES ON THE ASSUMPTION THAT THE CHARGES WILL BE PAID IN FULL BY YOUR INSURANCE COMPANY. NO INSURER PAYS 100% OF CHARGES. THERE ARE CO-PAYMENT(S), DEDUCTIBLE(S) AND NON COVERED CHARGE(S) AS WELL AS PERCENT PAYMENT(S). WE ARE TREATING YOU AS OUR PATIENT AND NOT YOUR INSURANCE COMPANY. THEREFORE, THE ULTIMATE RESPONSIBILITY FOR THE DEBT FALLS WITH YOU.**

*Medicare Patients:* Our office accepts Medicare assignments to assist our patients, but as most of our patients know, Medicare does not pay for ALL of your fees (80% of COVERED FEES) and is subject to a deductible and something they call "non covered fees". We will discuss this with you AGAIN prior to rendering any services, because you will be responsible for these fees.

*Blue Cross, Private Insurers and HMO's/PPO's:* Our office does accept most of the third party insurers and is associated with many of the HMO's/PPO's in our area. Each company establishes payment relating to the usual and customary fee scale that we mentioned above and establishes deductible(s) and co-pay(s). Prior to treatment we will try our best to give you an explanation of the costs you will incur if they exist, (deviations in usual and customary non-covered/co-pay(s)/deductible(s)) because you ultimately will be responsible for these fees.

*Fees and Billing:* After your initial examination with the doctor and staff, a therapy plan will be established as well as an itemized fee statement generated. At the same time we will discuss the fees and the reasonable expectations of your insurance company. This will remain in the chart, but please note this may deviate if any changes arise due to unforeseen conditions occurring in the therapy plan. After the services are performed your insurance will be filed immediately (in most cases electronically by computer/modem).

*A final note:* Financial problems arise rarely, and we take every step necessary to work with our patients. But in the event that *Cottage Hill Podiatry Group, PC* or their agents deem it is necessary to place this account with an attorney for the purpose of collection, the undersigned person agrees to pay any and all costs including but not limited to collection fees, court costs and reasonable attorney's fees in addition to the principal sum of the existing debt. The undersigned waives all claims of exemptions under the U.S. Constitution and State Law. Hopefully, this rarely comes about, but because of the actions of some patients in the past, we are forced to establish this written policy.

***Signature of Patient or Guardian*** _____ ***Date:*** _____

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## PATIENT'S INSURANCE AUTHORIZATION

I hereby authorize the processing of the medical insurance either by electronic or manual method by the listed provider below. My signature authorizes payment of all major medical and /or surgical benefits to which I am entitled from the listed insurer below, and to pay the listed provider assignee. I further authorize the assignee to release all medical and/or surgical insurance claim information necessary to secure payment(s). I recognize my financial obligation of any coinsurance or deductible, and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as the original.

Patient's Name (please print)

_____

Patient's Signature

_____

Patient's Insurance Company Name

_____

Patient's Insurance Policy Number

_____

Patient's Group Policy ID

_____

Date: _____

**Provider:**

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## CONSENT TO USE OF PROTECTED HEALTH INFORMATION (PHI)

Our notice of Privacy Practices provides information about how we may use and disclose Protected Health Information (PHI) about you. You have the right to review our Notice of Privacy Practices before you sign this consent. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a copy by requesting one from our Privacy Officer, Dr. Elliot Jay Braun.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to your requested restrictions. However, if we do agree, then we are bound by our agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

**Patient Signature:**_____ **Date:**_____

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## POLICY: PATIENT PRIVACY RIGHTS

Provider will implement policies and procedures relating to patient privacy rights as required by the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996.

Procedure:

*Patients cared for by the provider have the following privacy rights:

To receive a copy of the provider's Notice of Privacy Practices.

To request restrictions on the uses and disclosures of health information.

To request to receive confidential communication.

To access their protected health information for inspection and/or copying.

To request an accounting of disclosure of health information.

* Individuals have the right to complain if they believe the provider has committed any privacy violations.
* The privacy policies of the provider detail the requirements for each of these rights and provide procedures for implementation.
* Staff of the provider are provided with annual training regarding patient rights with regards to their health information.

**Patient Signature:**_____ **Date:**_____

Medicare Part B

# Extended Patient Signature Authorization

## TO BE COMPLETED BY PROVIDERS OF SERVICE—Please PRINT or TYPE

| Provider's Name *(If you are a DME supplier, please complete certification at bottom of page)* | Provider's I.D. Code |
|---|---|
| Provider's Address *(Street, City, State, ZIP Code)* | |

| Beneficiary's Name | Medicare HI Number | Applicable MEDIGAP Group Number |
|---|---|---|
| | | |

## TO BE COMPLETED BY BENEFICIARY OR AGENT—Directions For Payment Of Benefits And Release Of Medical Information

**STATEMENT FOR PAYMENT OF MEDICARE BENEFITS**

***I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ or to _____ (the Supplier) for any services or items furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.***

**STATEMENT FOR PAYMENT OF MEDIGAP BENEFITS**

***I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to _____ for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to (name of MEDIGAP insurer) _____ any information needed to determine these benefits or the benefits payable for related services.***

_____ _____
Signature of Beneficiary or person signing for Beneficiary — Date Signed

| Address of Person Signing For Beneficiary *(Street, City, State, ZIP Code)* | Relationship Of Agent To Beneficiary |
|---|---|
| | |

Reason Beneficiary Is Unable To Sign

## IMPORTANT INFORMATION FOR PHYSICIANS

In submitting claims under this procedure, PHYSICIANS undertake:

1. To complete and submit promptly the appropriate Medicare billing form for all services covered by the request for payment—even those in which the physician has not accepted assignment.
2. To incorporate, by stamp or otherwise, information to the following effect on any bills they send to Medicare patients: "DO NOT USE THIS BILL FOR CLAIMING MEDICARE BENEFITS. A CLAIM HAS BEEN OR WILL BE SUBMITTED TO MEDICARE ON YOUR BEHALF." This requirement is necessary to prevent patients from submitting duplicate claims.
3. To cancel the authorization on request by the patient.
4. To make the patient signature files available for carrier inspection upon request.

## IMPORTANT INFORMATION FOR SUPPLIERS

1. Only use this extended patient signature authorization for assigned claims.
2. Renew the patient signature agreement if a new item is rented or purchased.
3. Place alongside the beneficiary's signature the following statement: "RESPONSIBILITY FOR OVERPAYMENT ON ASSIGNED CLAIMS ACCEPTED."

## DURABLE MEDICAL EQUIPMENT SUPPLIERS AGREEMENT

**NOTE: THE FOLLOWING STATEMENT MUST BE SIGNED BY THE DME SUPPLIER PRIOR TO AUTHORIZATION OF PAYMENT FOR RENTAL OF DURABLE MEDICAL EQUIPMENT IN ASSIGNMENT CASES.**

***This supplier assumes unconditional responsibility for refunding of all overpayments for assigned claims for rental of durable medical equipment that may result from the failure of the Carrier to receive prompt notice of the return of, or the end of need for the rental of equipment, or the death or institutionalization of the Beneficiary.***

_____ _____
Signature of Durable Medical Equipment Supplier — Date Signed