LASER PODIATRY ASSOCIATES, LLC
Jennifer Mullendore, DPM, FACFAS
Kenneth Benjamin, DPM, FACFAS

Patient Registration
(PLEASE PRINT CLEARLY)

Patient's Name:_____ **SS #:**_____
First Name **MI** **Last Name**

Date of Birth:_____ **Age:**_____ **__Male__ Female** **__Single __Married __Widowed __ Divorced**

Street address:_____

City/State/Zip Code:_____ **Home phone with area code:**_____

Cell phone with area code:_____ **Email:** _____

Pharmacy name and phone with area code:_____

Patient's employer:_____**Occupation:**_____**Work phone with area code:**_____

Responsible party:_____ **Relationship: __Self __Spouse __Parent __Other:**_____

Responsible party's address:_____

In case of emergency, name of person to contact:_____

Phone number with area code:_____ **Relationship to patient:**_____

Is this work-related? __Yes __No If yes, date of injury?_____**Claim #:**_____

Primary Care Physician's name & phone number:_____

How did you hear about our office? _____

If patient is under the age of 18, a legal parent or guardian MUST accompany them for ALL visits. In the event that a parent or guardian is not able to attend the visit, a signed letter from the parent or guardian clearly stating the person authorized to consent to treatment must be brought for each visit.

Authorization to Disclose Health Information

By selecting appointment information this individual has the right to confirm, change, and cancel appointments, as well as know all past appointment history.

Name:_____ Relationship:_____
May disclose (select all that apply): □ Billing Information □Medical Information □Appointment Information

Name:_____ Relationship:_____
May disclose (select all that apply): □ Billing Information □Medical Information □Appointment Information

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID AND COMPLETE THE REQUESTED INFORMATION

Insurance Company # 1:_____ Phone Number:_____

Primary Insured's Name:_____ Date of Birth:_____

Policy #:_____Group #:_____ Relationship To Insured:_____

Insurance Company # 2:_____ Phone Number:_____

Primary Insured's Name:_____ Date of Birth:_____

Policy #:_____Group #:_____ Relationship:_____

- I hereby authorize the payment of medical benefits to **Laser Podiatry Associates, LLC** for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.
- I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce collection of any amounts outstanding.
- I hereby authorize **Laser Podiatry Associates, LLC** to release any medical information necessary to complete and process my insurance claims.
- I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf to Laser Podiatry Associates, LLC for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits payable for related services.
- I authorize Laser Podiatry Associates, LLC, Jennifer E Mullendore DPM and/or Kenneth Benjamin DPM to treat me and use my personal health information for healthcare operations.

_____ _____
Patient OR Insured Signature (legal guardian signature if patient is a minor) Date

MEDICAL HISTORY

Reason for Visit:

_____

_____

_____

Shoe Size: _____ Height: _____ Weight: _____ Do you smoke? □Yes □No Packs/day:_____

Past tobacco use? □Yes □No Do you drink alcohol? □Yes □No

Female patients: Are you pregnant? □Yes □No Nursing? □Yes □No

Have you had previous foot or ankle surgery? □Yes □No

Have you ever worn custom made arch supports (orthotics)? □Yes □No

Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest? □Yes □No

Do you experience any pain at rest in your lower leg(s) or feet? □Yes □No

Do you experience foot or toe pain that often disturbs your sleep? □Yes □No

Are your toes or feet pale, discolored, or bluish? □Yes □No

Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)? □Yes □No

Has your doctor ever told you that you have diminished or absent pedal (foot) pulses? □Yes □No

Have you suffered a severe injury to the leg(s) or feet? □Yes □No

Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? □Yes □No

Allergies: (please check those that apply or provide a list to copy)

□Penicillin	□Iodine	□Aspirin	□Adhesive Tape	□Sulfa
□Codeine	□Seafood/Shellfish	□Local Anesthetics	□Latex	□Other_____

Current Medications: Prescription and Non-prescription (Or provide a list to copy)

_____

_____

Prior surgery:

_____

_____

Illnesses: (Please check all that apply)

□Anemia	□Bleeding Disorders	□Hepatitis	□Lung Problems	□Stroke	□Other
□Arthiritis	□Diabetes	□High Blood Pressure	□Neck Pain	□Cancer	
□Asthma	□Gout	□Kidney Problems	□Numbness in Feet	□HIV/Aids	
□Back Pain	□Heart Disease	□Liver Disease	□Poor Circulation	□Blood clots	

Family History: (Please check all that apply)

□Anemia	□Bleeding Disorders	□Hepatitis	□Lung Problems	□Stroke	□Other
□Arthiritis	□Diabetes	□High Blood Pressure	□Neck Pain	□Cancer	
□Asthma	□Gout	□Kidney Problems	□Numbness in Feet	□HIV/Aids	
□Back Pain	□Heart Disease	□Liver Disease	□Poor Circulation	□Blood clots	

I hereby give my permission to the doctor(s) at Laser Podiatry Associates to perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in diagnosis and/or treatment of my feet and/or ankles.

PATIENT SIGNATURE: _____ DATE: _____

FINANCIAL POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. We accept Medicare benefit amounts. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for full payment of these services at the time of service.

OPTIMUM CHOICE/MD IPA: X-rays done in our office are not covered. In an effort to eliminate sending you to a radiology facility where you would be responsible for a co-pay and/or deductible amount, we can perform your x-ray for a fee of $30.00 which is payable at the time of service.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be given the option to sign a release stating you will get the referral to our office within 72 hours. If the referral is not received within this time frame, you will be financially responsible for all services received. You will also be given the option to reschedule your appointment.

CLAIM 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.

PATIENT BILLING: ***All co-payments, co-insurance, or deductible amounts must be paid AT THE TIME OF SERVICE*****.** This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion of insurance benefits at each visit. As a courtesy, our office does verify benefits with your insurance carrier; however, the insurance agreement is a contract between you and your insurance carrier. It is recommended that you verify your benefits with your carrier as well. After the first billing cycle, interest in the amount of 1.5% per month (18% per year) will be added to any existing balances.

PHYSICIAN PHONE CALLS/PAPERWORK: Phone calls with our physician are a billable service, may be billed to your insurance company/companies, and are subject to your insurance benefits. You are responsible for your portion of insurance benefits for physician phone calls. Any forms, letters or any other necessary paperwork you need filled out will be charged to you at $20.00 per form after the first one. This fee MUST be paid prior to our office releasing the forms.

NON-CUSTOM DURABLE MEDICAL EQUIPMENT RETURNS: If a patient is unsatisfied with any non-custom Durable Medical Equipment item, it must be returned within 30 days per Medicare guidelines. Returns after 30 days will not be permitted. The item will only be accepted as a return if it is in returnable condition. Any custom durable medical equipment item may not be returned for any reason.

COPY FEE: We will provide copies of patient records at the patient's request. Copies of records may be subject to a $0.25 per single page copy fee. You will bear complete financial responsibility for any fee(s) incurred. X-ray copies are $10.00 per film.

CANCELLED/MISSED APPOINTMENT FEE: If you cannot keep your appointment time, please call our office at least 24 hours prior to your scheduled appointment time. There may be a **$45.00 fee** for any appointment cancelled without 24 hour notice. If you miss 3 or more appointments, you may be required to pay a $50 deposit to hold any future appointment time slots. If you arrive more than 15 minutes late for an appointment, we will reschedule your appointment. You will bear complete financial responsibility for any fee(s) incurred. Repeated missed or late appointments may result in dismissal from our practice.

COLLECTIONS FEE: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account will be forwarded to our collection agency. If your account is sent to a collections agency, a **25% fee** will be added to your account. You bear complete financial responsibility for any fee(s) incurred.
Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA/Mastercard/Discover/American Express. An additional $35.00 will be added to your statement if the check is returned from your bank. We do not accept starter checks. In the event that your insurance company sends payment to you, the patient, it should be forwarded to our office to be applied to your balance.
I have read the above policy regarding my *financial responsibility* to Laser Podiatry Associates, LLC. for medical services provided. I agree to pay Laser Podiatry Associates, LLC. any balance unpaid by my insurance carrier for myself or the person named below.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to its terms.

Assignment of Benefits
I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Laser Podiatry Associates, LLC.** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees **AT THE TIME OF SERVICE**. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize Release of Medical Information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms:

PRINT Patient Name: _____ **Signature:** _____
Date:_____

FINANCIALLY RESPONSIBLE PARTY:
PRINT name:_____ **Signature:**_____
Relationship to Patient:_____ **Date**:_____