SCITUATE PODIATRY GROUP REGISTRATION FORM

PATIENT INFORMATION

NAME _____

ADDRESS _____

_____

City State Zip

E-MAIL ADDRESS _____

HOME PHONE _____

CELL PHONE _____

SEX: M__ F__ BIRTHDATE_____

Single Married Widowed Separated Divorced Partnered

EMERGENCY CONTACT _____

PHONE# _____

RELATIONSHIP _____

PRIMARY CARE PHYSICIAN _____

ADDRESS _____

PHONE# _____

LAST DATE YOU SAW YOUR PCP _____

RACE:

__White __American Indian or Alaska Native

__Asian __Native Hawaiian or Other Pacific Island

__Other __Unknown/Unreported

ETHNICITY:

__Hispanic or Latino __Not Hispanic or Latino

__Unknown/Unreported

LANGUAGE:

__English __Arabic __Chinese __Creole __Filipino

__French __German __Greek __Italian __Japanese

__Korean __Other __Portuguese __Spanish

__Vietnamese __Unknown/Unreported

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurace coverage with _____, and assign directly to Scituate Podiatry Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission, including Medicare and Medical.

_____

Signature

_____

Date

INSURANCE

INSURANCE CO. _____

SUBSCRIBER _____

RELATIONSHIP TO PATIENT _____

SUBSCRIBER BIRTHDATE_____

ADDITIONAL INSURANCE YES __ NO __

INSURANCE CO. _____

SUBSCRIBER _____

RELATIONSHIP TO PATIENT _____

SUBSCRIBER BIRTHDAY _____

FINANCIAL POLICY

Welcome and thank you for choosing our office for your Podiatric/foot care needs. In our continuing effort to provide personalized patient care in the most efficient and economical manner possible, we ask that you take a few moments to read our financial policy and fill out our medical history forms. Your clear understanding of our financial policy is important to our professional relationship. If you hae any questions about our fees, or your financial resposibilities for the services rendered, please do not hesitate to ask us. We are a Medical Provider and are also members of various insurance plans. It is your responsibilty to be sure we are on you insurance plan. If your insurance requires a referral or prior authorization, it is your responsibility to make sure that this is in place prior to your appointment. We will be glad to be of assistance, if we can. **Please remember that the agreement you have with your insurance company does not affect your responsibility for payment and all fees ultimately due from you to Scituate Podiatry.** Most health insurance plans will leave you with a co-payment, deductible, or sometimes a balance for non-covered services. Please be prepared to pay your portion at the time of services. We will be happy to bill your insurance company as a courtesy to you. If you have secondary insurance, we will bill them also. Complete payment for all podiatric soft goods, orthotics, supplies, and medications are due on the day these supplies are issued and these products are non-refundable.

IF FOR ANY REASON YOU NEED TO CANCEL YOUR APPOINTMENT, PLEASE GIVE A 24 HOUR NOTICE OR THERE WILL BE A $30 FEE.

CONSENT

I Certify that the above information is true and correct to the best of my knowledge, and I agree with the Financial Policy. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

_____

Signature

_____

Date