

SCITUATE PODIATRY GROUP REGISTRATION FORM

PATIENT INFORMATION	INSURANCE
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 _____	INSURANCE CO. _____ SUBSCRIBER _____ RELATIONSHIP TO PATIENT _____ SUBSCRIBER BIRTHDATE _____ ADDITIONAL INSURANCE YES ___ NO ___ INSURANCE CO. _____ SUBSCRIBER _____ RELATIONSHIP TO PATIENT _____ SUBSCRIBER BIRTHDAY _____
FINANCIAL POLICY	
<p>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 have any questions about our fees, or your financial responsibilities 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 responsibility to be sure we are on your 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. <u>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.</u> 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.</p>	
<p><u>IF FOR ANY REASON YOU NEED TO CANCEL YOUR APPOINTMENT, PLEASE GIVE A 24 HOUR NOTICE OR THERE WILL BE A \$30 FEE.</u></p>	
CONSENT	
<p>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.</p>	
<p style="text-align: center;">ASSIGNMENT AND RELEASE</p>	
<p>I, the undersigned, certify that I (or my dependent) have insurance 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.</p>	
Signature _____ Date _____	Signature _____ Date _____