VIP Podiatry

Patient Registration Form

Today's Date:

Patient Information

Last Name:	First Name:	Middle Initial:
Birth Date:	Age:	Sex:
SSN:	Email Address:	

Address:	Address 2:
City, State:	Zip Code:

Home Phone:	Cell Phone:

Primary Care Physician:	Referred by:

Insurance Information

Primary Insurance Name:	Name of Insured:
Member ID:	Group Number:

Secondary Insurance Name:	Name of Insured:
Member ID:	Group Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize VIP Podiatry or insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):	DOB:
Primary Care Doctor:	Date of last physical exam:
Height:	Weight:

PERSONAL HEALTH HISTORY

Chief Complaints:

History of Present Illness:

Current Medications:

Allergies to Medications:_____ Reactions: _____

HEALTH HABITS AND PERSONAL SAFETY

All questions contained in this questionnaire will be kept strictly confidential.

Do you drink alcohol? Yes: _____ No: _____

Do you use tobacco? Yes: _____ No: _____ Packs a day: _____ Quit Date: _____

Do you currently use recreational or street drugs? Yes: _____ No: _____

Patient Responsibility

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, refraction, testing, contact lens services and any other screening ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral.

I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. LLCEA/PS provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____	_____	_____
Printed Patient Name (and Guardian Name)	**Patient or Guardian Signature**	**Date**

I give permission to communicate my Private Healthcare Information to:

_____	_____
Name	Relationship
_____	_____
Name	Relationship

WHAT IF MY CHILD NEEDS TO SEE THE PHYSICIAN?

A PARENT OR LEGAL GUARDIAN MUST ACCOMPANY PATIENTS WHO ARE MINORS ON EACH PATIENT'S VISIT. THIS ACCOMPANYING ADULT IS RESPONSIBLE FOR PAYMENT OF THE ACCOUNT, ACCORDING TO THE POLICY OUTLINED ON THE PREVIOUS PAGES.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE FINANCIAL POLICY. I UNDERSTAND THAT CHARGES NOT COVERED BY MY INSURANCE COMPANY, AS WELL AS APPLICABLE COPAYMENTS AND DEDUCTIBLES ARE MY RESPONSIBILITY. I AGREE TO PAY FOR ALL ATTORNEY'S FEES, COURT COSTS AND FILING FEES, INCLUDING CHARGES THAT MAY BE ASSESSED BY OUR COLLECTION AGENCY TO PURSUE COLLECTION OF MY ACCOUNT. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO: SUN CITY MEDICAL CENTER DBA VIP PODIATRY. I AUTHORIZE SUN CITY MEDICAL CENTER TO RELEASE PERTINENT MEDICAL INFORMATION TO MY INSURANCE COMPANY WHEN REQUESTED, OR TO FACILITATE PAYMENT OF A CLAIM.

By signing below, I acknowledge that I have read, understand, and accept the policy.

Print Name: _____ Date of Birth: ____/____/_____
mm dd yyyy

Signature: _____ Date: ____/____/_____

PATIENT AGREEMENT

PATIENT PAYMENT POLICY

THANK YOU FOR CHOOSING OUR PRACTICE! WE ARE COMMITTED TO THE SUCCESS OF YOUR MEDICAL TREATMENT AND CARE. PLEASE UNDERSTAND THAT PAYMENT OF YOUR BILL IS PART OF THIS TREATMENT AND CARE. FOR YOUR CONVENIENCE, WE HAVE ANSWERED A VARIETY OF COMMONLY-ASKED FINANCIAL POLICY QUESTIONS BELOW. IF YOU NEED FURTHER INFORMATION ABOUT ANY OF THESE POLICIES, PLEASE ASK TO SPEAK WITH A BILLING REPRESENTATIVE OR THE PRACTICE MANAGER.

HOW MAY I PAY?

WE ACCEPT PAYMENT BY CASH, CHECK, AND APPLE PAY OR ANY MAJOR CREDIT CARD.

DO I NEED A REFERRAL?

IF YOU HAVE AN HMO PLAN WITH WHICH WE ARE CONTRACTED, YOU NEED A REFERRAL AUTHORIZATION FROM YOUR PRIMARY CARE PHYSICIAN. IF WE HAVE NOT RECEIVED AN AUTHORIZATION PRIOR TO YOUR ARRIVAL AT THE OFFICE, WE HAVE A TELEPHONE AVAILABLE FOR YOU TO CALL YOUR PRIMARY CARE PHYSICIAN TO OBTAIN IT. IF YOU ARE UNABLE TO OBTAIN THE REFERRAL AT THAT TIME, YOU WILL BE RESCHEDULED.

WHICH PLANS DO YOU CONTRACT WITH?

YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ACCEPT ASSIGNMENT OF INSURANCE BENEFITS. HOWEVER, **IT IS YOUR RESPONSIBILITY TO CALL YOUR INSURANCE COMPANY PRIOR TO YOUR FIRST OFFICE VISIT TO DETERMINE YOUR BENEFITS, YOUR CO-PAYMENT, DEDUCTIBLE OR IF YOU REQUIRE AN AUTHORIZATION TO SEE A SPECIALIST**.

WHAT IF I REQUIRE FORMS TO BE FILLED OUT BY THE PHYSICIAN (FMLA, DISABILITY, INSURANCE COMPANY FORMS, DMV FORMS) WHAT IS THE PROCESS AND IS THERE A FEE?

WE CANNOT FILL IN FORMS "ON DEMAND". ALL FORMS WILL BE PROCESSED AND COMPLETED IN A **7 DAY** PERIOD OF TIME. THE FEE FOR EACH FORM IS **$15.00**. PLEASE BE ADVISED THAT IF YOUR SHORT/LONG TERM DISABILITY PROVIDER IS NOT RESPONSIBLE FOR REPRODUCTION AND DELIVERY OF MEDICAL RECORDS, THEN PAYMENT REQUESTS WILL BE DIRECTED TO THE PATIENT. COPIES OF ANY IN HOUSE STUDIES WILL BE **$0.60 PER PAGE** FOR PAPER COPIES OF MEDICAL RECORDS. **COMPLETED PAPERWORK MUST BE PICKED UP FROM OUR OFFICE. PAPERWORK CANNOT BE FAXED.**

WHAT IF I DO NOT HAVE INSURANCE?

PATIENTS WHO DO NOT HAVE INSURANCE ARE REQUIRED TO SPEAK TO MANAGEMENT PRIOR TO RECEIVING TREATMENT AND ON A CASE BY CASE BASIS WILL OFFER A PAYMENT STRUCTURE.

WHAT IS THE PROCEDURE IF I REQUIRE SURGERY?

IF YOUR PHYSICIAN RECOMMENDS SURGERY, YOU WILL BE ESCORTED TO HIS SURGERY COORDINATOR. OUR SURGERY SCHEDULER WILL ANSWER SPECIFIC QUESTIONS ABOUT THE SURGERY SCHEDULING PROCESS, DISCUSS THE PAPERWORK AND TESTS INVOLVED, AND COMPLETE ALL PRE-CERTIFICATION/AUTHORIZATION IF YOUR INSURANCE COMPANY REQUIRES IT. THE SURGERY COORDINATOR WILL REQUEST A PRE-SURGICAL DEPOSIT, THE AMOUNT OF WHICH DEPENDS ON YOUR COVERAGE AND DEDUCTIBLE AMOUNT. A COST ESTIMATE WHICH SHOWS YOUR FINANCIAL RESPONSIBILITY, BASED ON THE BENEFIT LEVELS AND COVERAGE OF YOUR INSURANCE PLAN, WILL BE EXPLAINED BY THE SURGERY COORDINATOR.

Patient Financial Policy

It is the policy of Vip Podiatry to provide you with information related to our billing processes and your financial responsibilities as our patient. This policy helps us in our mission to provide you with exceptional medical care in the most cost-effective manner.

Things to bring with you to each visit:

1) Current insurance card(s)

2) Photo identification

3) Your preferred method of payment for any cost shares due at the time of service

Insurance Companies: Participation and Billing

1) While VIP Podiatry participates with the majority of third-party insurance plans available in our area; it is **your** responsibility to verify that your physician is currently participating with your plan and that you have obtained all necessary referrals and authorization **PRIOR** to your scheduled appointment. You are responsible to designate your physician as the preferred podiatrist with your insurance plan. Failure to do so may result in your responsibility for any incurred charges.

2) You will be asked to provide your insurance card(s) at every visit. This is to ensure that the information we have on file is correct, and that your plan is current.

3) Except where my plan provides for automatic payment of benefits to the provider of services, I authorize payment of benefits, otherwise payable to me, for services rendered by Vip Podiatry. I understand that I am ultimately responsible to the provider for charges NOT covered by my benefit plan.

4) Due to the wide range of insurance plans, we are unable to quote specific plan benefits. To fully understand your individual insurance plan, please contact your insurance company directly to discuss your plan's benefits.

Time of Service Payments

1) Co-payments, deductibles and coinsurance are part of the contractual agreement between you and your insurance company. Your insurance company requires us to collect your co-payment in full at the time of service. If your plan also has a deductible and/or coinsurance that hasn't been met, we may collect a deposit of $150.00 (since we can only estimate the future amount due) at the time of service.

2) Patients without medical insurance coverage (self-pay patients) are responsible for any and all charges that result from professional or medical services provided by our physicians. Payment is due when services are rendered, unless other payment arrangements have been approved.

Collections

1) The practice reserves the right to consider delinquent patient accounts for external collection efforts in accordance with state and federal regulations.

By signing below, I acknowledge that I have read, understand, and accept the policy.

Print Name: _____ Date of Birth: ____/____/_____
mm dd yyyy

Signature: _____ Date: ____/____/_____

Sun City Medical Center / VIP Podiatry

CANCELLATION POLICY / NO SHOW POLICY

We understand that there are times when you miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit due to a seemingly "FULL" appointment book.
The reminder call is only a courtesy call.
If an appointment is not cancelled at least 24 hours in advance, you will be charged a **Forty-Five Dollar ($45) fee**.
Your insurance company will not cover this fee.

Scheduled Appointments

We understand that delays can happen, however, we must try to keep the other patients and doctor on time. If a patient is 15 minutes past their schedule time, we will have to reschedule the appointment.

_____
Patient Name Print

_____
Signature Patient / Guardian

_____/_____/_____
Date