

CORINTH PODIATRY GROUP, INC.
Medical & Surgical Treatment of the Foot
W. Christopher Cox, D.P.M.

(913) 491-3311

(816) 461-3535

Welcome to our office. Please answer the following questions completely. If you need assistance, please ask the front office assistant at the desk. Thank you.

DATE _____

NAME: Last _____ First _____ Middle _____

ADDRESS: Street _____ City _____ State ____ Zip _____

PHONE #'s: Home () _____ Work () _____ other () _____

SOCIAL SEC. #: _____ **BIRTHDATE:** _____ **Sex:** _____ **MARITAL STATUS:** SMDW

EMPLOYER: Business Name _____

OCCUPATION: _____

PRIMARY CARE PHYSICIAN: Name _____

WHO MAY WE THANK FOR REFERRING YOU: **PCP** **FRIEND** **INTERNET** **YELLOW PAGES**

EMERGENCY CONTACT: Name & Phone Number: _____

PHARMACY: Name & Phone Number: _____

RESPONSIBLE PARTY INFORMATION (if patient is a minor)

NAME: Last _____ First _____ Middle _____

ADDRESS: Street _____ City _____ State ____ Zip _____

PHONE #'s: Home () _____ Work () _____ Other () _____

SOCIAL SECURITY #: _____ **BIRTHDATE:** _____ **RELATION:** _____

EMPLOYER: Business Name _____

INSURANCE INFORMATION

PRIMARY INSURANCE: Name _____

SUBSCRIBER'S NAME: _____ **Relationship to patient:** _____

ID #: _____ **Group #:** _____ **Is this an employer plan?** Yes No

SUBSCRIBER'S EMPLOYER: _____ **Subscriber's Date of Birth:** _____

SECONDARY INSURANCE: Name _____

SUBSCRIBER'S NAME: _____ **Relationship to patient:** _____

ID #: _____ **Group #:** _____ **Is this an employer plan?** Yes No

SUBSCRIBER'S EMPLOYER: _____ **Subscriber's Date of Birth:** _____

CONSENT FOR TREATMENT AND FINANCIAL ARRANGEMENTS

I hereby consent to and authorize any examination and administration of all treatments that may be considered advisable or necessary in the judgment of the physician. I understand that charges will be made for the services of Corinth Podiatry Group, Inc. and for x-ray, laboratory, drugs, and other services. I, and any representative signing for me agree to pay for charges when billed. I authorize direct payment to Corinth Podiatry Group, Inc. of any insurance or health plan benefits applicable to said charges. I authorize Corinth Podiatry Group, Inc. to release any medical or other information about me to my insurance company or health plan, attending, family, referral and/or company physician. If my account is referred to an attorney/collection agency, I agree to pay attorney's fees and cost of collection.

Signature of Responsible Party

Date

(Turn Page Over)

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This release gives **CORINTH PODIATRY GROUP** the authorization to release my health information, either by phone or a copy of my records to the following persons: _____

_____.

1. I understand that this authorization will expire upon no longer being treated by **CORINTH PODIATRY GROUP** or two years from my last appointment on file.
2. I understand that I may remove these person/persons at any time by notifying **CORINTH PODIATRY GROUP**.
3. I understand that if I do not enter anyone in the above area, my insurance company, primary care physician, and/or other healthcare provider will be the only ones having access to my protected health information.
4. I may have access to my personal health information by copies of either chart notes or x-rays (charges may vary).
5. I understand that if the person/persons or organization that receives my protected information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.
6. I authorize **CORINTH PODIATRY GROUP** to leave me messages on the following phone numbers: _____.

Patient's signature or Patient's Representative

Date

LIST ANY PREVIOUS SURGERIES YOU HAVE HAD

TYPE OF SURGERY	DATE	ANY COMPLICATIONS?

PLEASE ANSWER THE FOLLOWING PAST MEDICAL HISTORY QUESTIONS:

Pneumonia	YES	NO	Cancer/Tumors	YES	NO
Arthritis/Gout	YES	NO	Hay Fever/Asthma	YES	NO
Nervous Disorder	YES	NO	Thrombophlebitis (blood clots)	YES	NO
Stroke	YES	NO	Frequent Colds/Sore Throat	YES	NO
Epilepsy	YES	NO	Bone Disease	YES	NO
High/Low Blood Pressure	YES	NO	Bleeding Tendencies	YES	NO
Diabetes	YES	NO	HIV/AIDS	YES	NO
Skin Disease	YES	NO	Liver Disease	YES	NO
Varicose Veins	YES	NO	Swollen Feet/Ankles	YES	NO
Keloid (scar) Formation	YES	NO	Tuberculosis	YES	NO
Anemia	YES	NO	Hepatitis	YES	NO

REMARKS: If any of the above questions are circled YES, please explain including date of onset, severity, persistency of symptoms, and your physician currently caring for this problem: _____

FAMILY HISTORY – HAS ANY RELATIVE EVER HAD THE FOLLOWING:

CONDITION:	YES	NO	FAMILY MEMBER:
Cancer/Tumor	YES	NO	
High/Low Blood Pressure	YES	NO	
Diabetes	YES	NO	
Skin Disease	YES	NO	
Varicose Veins	YES	NO	
Heart Trouble	YES	NO	
Bunions	YES	NO	
Hammertoes	YES	NO	
High Arches	YES	NO	
Flat Feet	YES	NO	

Signature of Responsible Party/Patient

Date

FINANCIAL POLICY

Thank you for choosing CORINTH PODIATRY GROUP as your health care provider. We are committed to the successful treatment of your condition. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important in our professional relationship. Please call our billing department at (913) 814-9841 if you have any questions.

- WE ARE HAPPY TO BILL YOUR INSURANCE DIRECTLY, HOWEVER, WE MUST HAVE A CURRENT COPY OF YOUR INSURANCE CARD(S), PRIMARY AND SECONDARY. PATIENTS MUST PRESENT THEIR INSURANCE CARD(S) AT EACH APPOINTMENT.
- **IF PAYMENT IS NOT RECEIVED FROM THE INSURANCE CARRIER OR OTHER RESPONSIBLE THIRD PARTY WITHIN 90 DAYS, WE HAVE THE RIGHT TO BILL YOU DIRECTLY.**
- IF YOU DO NOT HAVE INSURANCE FULL PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AND DISCOVER.
- IF YOU DO NOT HAVE YOUR INSURANCE CARD(S) WITH YOU A WAIVER **MUST** BE SIGNED STATING YOUR UNDERSTANDING THAT ULTIMATE RESPONSIBILITY FOR PAYMENT IS YOURS.
- ALL PATIENTS MUST COMPLETE OUR PATIENT REGISTRATION FORMS AND OTHER RELATED FORMS REQUIRED FOR TREATMENT.
- PLEASE NOTIFY US IMMEDIATELY OF ANY CHANGES IN YOUR INSURANCE AND/OR COVERAGE.
- 48-HOUR NOTICE IS REQUIRED FOR COPIES OF MEDICAL RECORDS/X-RAYS. A COMPLETED RELEASE FORM MUST BE SIGNED AND THERE IS A NOMINAL FEE FOR OBTAINING RECORDS.
- THERE WILL BE A \$25.00 INITIAL CHARGE FOR COMPLETING FMLA FORMS, ANY FORMS THEREAFTER IS A \$10 FEE

SELF - PAY

We expect payment at the time services are rendered unless prior arrangements have been made. We accept Cash, Check, Visa, MasterCard, and Discover.

MEDICARE

We accept Medicare assignment. As a Medicare patient you are responsible for difference between the approved charge and the amount Medicare pays. As a Medicare patient you are also responsible for your deductible, if your plan has one. If you have supplemental insurance we will be happy to bill it directly for you. You will receive a bill after your insurance has paid.

HMO/PPO

ALL CO-PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED. We are contracted with most commercial insurance plans, but not all of them. You are responsible for verifying whether we participate with your insurance plan or not. If you are an HMO member you will not be billed as long as you provide the necessary referrals.

ALL HMO PATIENTS MUST HAVE A REFERRAL PRIOR TO BEING SEEN BY OUR PHYSICIANS. PPO patients will only be responsible for their co-payments and co-insurance as long as it has been verified that we participate with your insurance plan.

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WORKERS' COMPENSATION

If you are here as a result of a work related injury, we will require information regarding both health insurance and your employer's Workers' Compensation insurance. From the Workers' Compensation carrier we will require a letter authorizing your treatment. This letter must include the claim number, address, and adjuster's name and phone number. (This information can be obtained through your employer's Human Resources department.) If payment is not received from these third parties within 90 days, we have the right to bill you directly.

ACCIDENT CLAIMS

If you are here as a result of an accident claim, we will require information regarding both health insurance and accident insurance. In addition, we must have the name, address, and phone number of your attorney. In the case of a lawsuit, we may need to file liens for payment. If payment is not received from these third parties within 90 days, we have the right to bill you directly.

USUAL AND CUSTOMARY RATES (UCR)

We are committed to providing the best treatment possible for our patients and we charge what is usual and customary for our geographic area. If we do not have a contract with your insurance company, you are responsible for full payment regardless of any insurance company's arbitrary determinations in UCR cases.

CANCELLATIONS AND NO SHOW APPOINTMENTS

Effective January 2002, there will be a \$15 charge for appointments that are not cancelled 24 hours prior to the original appointment date. Additionally, if a patient has an appointment and "no-shows" to the appointment there will be a \$15 charge. Such fees are not payable by insurance. Effective October 2003, there will be a \$50 charge for in-office surgical appointments not cancelled 24 hours prior to the scheduled surgery. Such fees are not payable by insurance and are the responsibility of the patient.

I understand that if the office agrees to bill my insurance as a courtesy that I must submit information as needed to ensure timely payment for services rendered to me. I additionally understand that I am ultimately responsible for payment of all services.

Printed Name of Patient or Responsible Party

Signature of Patient or Responsible Party

Date Signed