MICHIGAN FOOT AND ANKLE CENTER

REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name:	First	Middle	☐ Mr. ☐ Mrs. ☐ Dr. ☐ Miss	☐ Sr. ☐ Jr.

Street Address	City	State	Zip Code

Home Phone	Work Phone	Cell Phone

Birth Date	Age	Social Security Number	Sex ☐ Male ☐ Female ☐ Transgender

Email Address

EMERGENCY CONTACT

Name	Phone	Secondary Phone

INSURANCE INFORMATION

Primary Insurance Company:

Policy Holder's Name	Insured S.S.#	Insured Birthdate

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

PHARMACY

Pharmacy Name:

City: Intersection:

PRIMARY CARE PHYSICIAN

Please Indicate Primary Care Physician	Phone Number

Street Address	City	State	Zip Code

Whom may we thank for reffering you to our office?

I hearby authorize my assignment of benefits to Beyond Podiatry . This will allow Beyond Podiatry to receive payment for services directly from my insurance company.

PATIENT NAME PRINTED

PATIENT /GUARDIAN SIGNATURE DATE

MEDICAL HISTORY

ALLERGIES (LIST KNOWN ALLERGIES AND REACTIONS TO DRUGS/MEDICATIONS)

MEDICATIONS (PLEASE LIST CURRENT MEDICATIONS THAT YOU ARE TAKING)

MEDICATION	DOSE	MEDICATION	DOSE

Past Surgeries:

SOCIAL HISTORY

Daily Alcohol Consumption	Weekly Alcohol Consumption	Monthly Alcohol Consumption
Do you smoke? ☐ Yes ☐ No	How much do you smoke a day?	
Marital Status	Shoe Size	Shoe Style
Occupation	Height	Weight

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT.

Arthritis (Specify Below)	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Artificial Joints (Specify Below)	☐ Yes	☐ No	H.I.V. Positive	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No
Cancer (Specify Below)	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Neurological Disorder	☐ Yes	☐ No
Heart (Surgery, Disease, Attack)	☐ Yes	☐ No	Psychiatric/Psychological Care	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Stomach Problems/Reflux/Heartburn	☐ Yes	☐ No
Hepatitis (Specify Below)	☐ Yes	☐ No	Ulcers of the Leg and Foot	☐ Yes	☐ No
Put to sleep for surgery	☐ Yes	☐ No	Currently Pregnant	☐ Yes	☐ No

Other or Specify from above:

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of any changes in my health, medication, or insurance information.

PATIENT NAME PRINTED

PATIENT /GUARDIAN SIGNATURE DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you are agreeing that you understand Beyond Podiatry's privacy notice, which describes how we use and disclose your health information.

Beyond Podiatry's document explains how Beyond Podiatry's will use your health information for the purposes of your treatment, payment of your treatment, and health care operations. The notice explains in more detail how Beyond Podiatry will use your health information as required/permitted by law.

I consent to Beyond Podiatry using and disclosing my treatment for the purposes detailed in the notice. I consent to Beyond Podiatry leaving me a message on my answering machine.

I understand that I may revoke this authorization at any time by notifying Beyond Podiatry in writing. However, if I choose to do this, I understand that my revocations do not affect any action taken by Beyond Podiatry before receiving my notice. This authorization does not expire unless a request is made in writing.

I understand that I can request a copy of Beyond Podiatry's Privacy Policy at any time.

I hereby authorize Beyond Podiatry to release / disclose the contents of my medical record to the following people:

Name	Relationship To Patient

I have reviewed and understand Beyond Podiatry's Notice of Privacy Practices. I understand how my medical information may be used, disclosed, and how I can gain access to this information.

PATIENT NAME PRINTED

PATIENT /GUARDIAN SIGNATURE DATE

CIRCLE OF CARE

Beyond Podiatry is grateful for the privilege to participate in your circle of care. We consider it a priority to maintain profes-sional communication with those who are involved in your medical care.

Please indicate below any other healthcare professionals or specialty doctors that are involved in your circle of care.

Physician Name:	Specialty:
Town:	Phone Number:

Physician Name:	Specialty:
Town:	Phone Number:

Physician Name:	Specialty:
Town:	Phone Number:

Beyond Podiatry FINANCIAL POLICY

Copayments, coinsurance, and all applicable deductibles are due at the time services are rendered. We accept cash, check, Visa, MasterCard, Discover and American Express.

If you have medical insurance, Beyond Podiatry will submit claims directly to your insurance company. Your insurance is a contract between you, your employer and the insurance company. Beyond Podiatry is not a party to that contract. Not all services are a covered benefit with all contracts, and it is your responsibility to be aware of what benefits your insurance entitles you to. We will assist you to receive your maximum allowable benefits. We emphasize that as medical care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility. As the guarantor and/or patient, you agree to pay any balance that becomes patient responsibility upon receipt of a statement.

We reserve the right to implement a service fee of $50.00 for all appointments missed or cancelled without a 24 hour notice.

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. You must inform the office of all insurance changes and authorization/referral requirements. In the event that the office is not informed, you will be responsible for any charges denied.

There are certain elective surgical and non/surgical procedures that we require pre-payment. You will be informed in advance if your procedure falls into this category. Payment is due prior to the services being performed.

I understand that if I do not abide by the financial agreement as noted above, that any balance not paid within 90 days from the date that the balance becomes my responsibility, Beyond Podiatry will turn my account over to a collection agency and I will be responsible for all collection and legal fees that the Practice incurs as a result. Beyond Podiatry reserves the right to refuse service to any patient that has been placed into collections.

I agree and understand all the above statements regarding financial arrangements and insurance. I authorize Beyond Podiatry to submit my claims and remit insurance payment of medical benefits directly to Beyond Podiatry.

Name of Patient/Guarantor if Minor _____

Authorization Signature_____Date_____

Signature is required for acknowledgement/receipt of financial policy and insurance/patient billing authorization

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CREDIT CARD: **VISA** **MC** **DISCOVER** **AMEX**

CC NUMBER:_____ **EXP DATE**_____**CVV**_____

Name on Card_____