



**VALLEY
PODIATRY
ASSOCIATES, P.C.**

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Podiatric Medicine and Surgery

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PATIENT REGISTRATION FORM

Date: _____

Patient's Name: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ SSN: _____ Marital Status: M S W D

Spouse's or Parent's Name: _____

In Case of Emergency, person to notify: _____

Address: _____ Phone: _____

Patient's Occupation and Employer: _____

PRIMARY INSURANCE (Medicare, Blue Cross & Blue Shield, Commercial Insurance, etc.)

Insurance: _____ Policy Number: _____

Subscriber (Name of Insured): _____ SSN: _____ DOB: _____

Insurance Company Address: _____

Authorization Phone Number: _____

Policy Holder's Name (Employer): _____ Effective Date: _____

Address: _____

Patient Relationship to Insured: Self Spouse Child Other _____

SECONDARY INSURANCE

Insurance: _____ Policy Number: _____

Subscriber (Name of Insured): _____ SSN: _____ DOB: _____

Insurance Company Address: _____

Authorization Phone Number: _____

Policy Holder's Name (Employer): _____ Effective Date: _____

Address: _____

PRIMARY CARE PHYSICIAN: _____ Phone: _____

Is this a work related injury or an injury incurred by an automobile accident? _____

Have you ever seen another physician in this group? _____

FOOT COMPLAINT: _____

Authorization/Financial Policy

Payment - Payment in full is expected upon completion of each visit. For your convenience, we accept MasterCard, Visa, American Express and Discover, as well as personal checks* (accepted with proper identification). **Please note – there is a returned check fee of \$10.00.*

Insurance – As a service to our patients, our office will submit fees for service to certain insurance companies. However, we do consider the patient (or guarantor) primarily responsible for the account. Any co-payments, deductibles or patient responsibilities known prior to the visit will be collected at, or before, the time services are rendered. When claims have been processed by insurance, any remaining balance – if any, is the patient's responsibility. Additionally, the practice is not responsible for knowing what specific procedures or amounts are covered by your insurance policy or the limits of your coverage.

Medicaid – We do not accept Medicaid (MassHealth)

Cancellation – We require one full (24 hours) business day's notice for cancellation of all scheduled appointments. **There may be a cancellation charge of \$35.00 for all failed and cancelled appointments (with less than 24 hours notice).** This is NOT a covered expense by insurance companies.

Medical Records – There is a fee charged for all copies of medical records and/or radiographs. This request must be made, in writing, 5 business days prior to the date needed and payment must be made at the time of the request. Patient understands that x-rays and charts are part of permanent medical record and are the property of Valley Podiatry Associates, P.C.

Purchase Policy – Please note that any products purchased from Valley Podiatry Associates are non-returnable and nonrefundable (except in the case of manufacturers defect).

I desire to have Valley Podiatry Associates, P.C. provide me with professional services and agree to abide by this authorization/policy.

I agree to pay any balance due to the practice of Valley Podiatry Associates within 30 days of receiving notification (which may be provided via mailed statements, letters and/or telephone) of said balance.

I understand that legal action may be taken if I fail to fulfill this contract, and I will be responsible for all collection costs incurred, as well as any additional attorney's fees that may be assessed by the court.

I hereby authorize any physician, health care practitioner, hospital or medical care facility to provide all information on patient's medical history to Valley Podiatry Associates, P.C.

I hereby authorize photocopies of this form to be valid as the original.

Patient/Guarantor Signature (Parent or Guardian if patient
is a minor or incompetent)

Date

Printed Name

Patient Name (printed) if different from guarantor