Valley Podiatry
ASSOCIATES, PC

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Podiatric Medicine and Surgery

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PATIENT REGISTRATION FORM

Date:_____ Patient's Name: _____

Sex: M F _____ Date of Birth: _____ Age: _____ Marital Status: M S W D P

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

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

Send *automated* reminder calls to: (Choose One) ☐ Home ☐ Cell (Choose One) ☐ Voice ☐ Text

Email Address: _____

When we need to contact you can we leave a detailed message? ☐ Yes Would you prefer to call us back ☐

In Case of Emergency, person to notify: _____ Relationship: _____

Address: _____ Phone: _____

RACE:
☐ Asian ☐ White ☐ Other Pacific Islander
☐ Native Hawaiian ☐ Hispanic ☐ Refused to Report
☐ Black or African American ☐ Other Race

ETHNICITY: ☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ Refused to Report

LANGUAGE:
☐ English ☐ Russian ☐ Other
☐ Spanish ☐ Indian (includes Hindi & Tamil)

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

Insurance: _____ Policy Number: _____ Effective Date: _____

Subscriber (Name of Insured): _____ DOB: _____

For Tricare insurance only, Sponsor SSN: _____

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

SECONDARY INSURANCE:

Insurance: _____ Policy Number: _____ Effective Date: _____

Subscriber (Name of Insured): _____ DOB: _____

For Tricare insurance only, Sponsor SSN: _____

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

PRIMARY CARE PHYSICIAN: _____ Phone: _____

What local pharmacy do you use? _____

Do we have your permission to send prescriptions to your pharmacy electronically? _____

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

Have you seen another physician in this group? _____

FOOT COMPLAINT: _____

Please read and sign reverse for treatment.

Authorization/Financial Policy

Payment - Payment/co-payment in full is expected upon completion of each visit. **Any late co-payments will be subject to a $15.00 service charge.** 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 $25.00.*

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 a full (24 hours) business day's notice for cancellation of all scheduled appointments. **There may be a cancellation charge 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 non-refundable (except in the case of manufacturer's 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 Valley Podiatry Associates, P.C. to view my external prescription history from multiple other unaffiliated medical providers and insurance companies. Prescription information may be dated back several years. Initial here to refuse:_____

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)

D.O.B.

Date

_____ _____

Printed Name

Patient Name (printed) if different from guarantor