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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: SSN: Marital Status: M S W D P
Address: City: State: Zip:
Home Phone: Work Phone: Cell Phone:
Email Address:
How do you prefer we contact you? Phone Mail. If phone, can we leave a message? Yes No
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): SSN: DOB:
Patient's Relationship to Insured: Self Spouse Child Other

SECONDARY INSURANCE:
Insurance: Policy Number: Effective Date:
Subscriber (Name of Insured): SSN: DOB:
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