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FINANCIAL POLICY

To provide the best possible care to ALL our patients, we must work hard to keep our finances in order. To achieve this goal, we would like to clarify the financial policy that governs our practice:

1. We share your concerns about the increasing costs of quality health care. Asking for payment at the time of service helps us to lower our expenses and keep costs down.

2. Our services are provided to our patients, NOT to insurance companies. The financial responsibility is yours, regardless of insurance coverage. Health insurance is a contract between you and your insurance carrier, to reimburse you for covered medical services. Unfortunately, some services are not covered.

3. Insurance coverage is determined by your contract with the insurance company. As a courtesy, we will file your insurance for you, but again, you will still be responsible for any unpaid fees which include deductibles, coinsurance and copays.

4. **We do participate with several insurance carriers and will file ALL insurance(s) regardless of participation; however, it is the responsibility of the patient to verify if we are In-Network or Participating providers with their insurance company. New patients' insurance cannot be filed unless we receive a copy of the insurance cards on the first visit. In addition, it is also the patient's responsibility to keep up with referrals/authorizations if required by his/her insurance carrier.**

5. Bills not paid by insurance remain the responsibility of the patient. Claims not paid by the insurance company within 90 days will be billed to the patient.

6. Failure to pay on accounts over 60 days will result in the account being turned over to collections and incurring additional fees.

7. A 24-hour notice must be given when canceling an appointment or a fee may be charged. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignment.

I understand what the financial policy states above, and understand, as a patient, I have certain obligations for my care.

Signature of Patient/Responsible Party _____ Date _____

2500 Starling Street, Suite 301 * Brunswick GA 31520 * (912) 265-4766 * Fax: (912) 267-9857
600 Oglethorpe Highway * Hinesville GA * (912) 368-3036 * Fax: (912) 368-3526

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Full Name: _____ Birth Date: _____ Age: _____

Billing Address: _____ City, State, Zip: _____

Marital Status: S___ M___ W___ D___ Sex: M___ F___ SS#: _____

Home Phone: _____ Cell Phone: _____

Preferred Calling: Home___ Cell___ Preferred Appointment Reminders: Call___ Text___

E-Mail Address: _____

Race: American Indian or Alaska Native - Asian - Black or African American - White

Native Hawaiian or Pacific Islander - Two or More - Other Race _____

Ethnicity: Hispanic or Latino - Not Hispanic or Latino

Patient Employer: _____ Work Phone #: ( )_____

Employer Address: _____ City, State, Zip: _____

Spouse/Guardian:_____ Social Security #:_____ Date of Birth:_____

Spouse/Guardian Employer: _____ Work Phone:_____

Emergency Contact: _____ Phone #: ( )_____ Relationship: _____

Primary Care Physician: _____ Date of Last Visit: _____

Diabetic Care Physician (Only needed if you're diabetic) _____ Date of Last Visit: _____

INSURANCE

We **MUST** have a copy of your insurance card(s) to file your insurance. Please provide this information to the front desk. If insured is other than self, ALL fields must be filled out for us to file your insurance.

Primary _____ Insured's Name (if different from self) _____
Insured's DOB _____ Insured's SSN _____ Relation to patient _____

Secondary_____ Insured's Name (if different from self) _____
Insured's DOB _____ Insured's SSN _____ Relation to patient _____

Signature of Patient/Responsible Party: _____ **Date**_____

The information stated above is true and correct to the best of my knowledge.
If the patient is under the age of 18, a parent or legal guardian must sign.

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Name: _____ **Age:** _____ **DOB:** _____

Describe the problem you are having: _____

_____

When did it first start? _____

Have you tried any treatment? Describe: _____

_____

MEDICAL HISTORY: YES OR NO

****CIRCLE ALL THAT APPLY****

AIDS/HIV	Anemia	Arthritis	Asthma	Bleeding Problems	Blood Clots
Cancer	Diabetes	Gout	Heart Disease	Hepatitis	High Cholesterol
Kidney	Leg Cramps	Liver Disease	Phlebitis	Poor Circulation	High Blood Pressure
Seizures	Sickle Cell	Stomach Ulcers	Stroke	Thyroid Disease	Other _____

Are you currently taking any medications: YES or NO: Please list prescription name, dosage and milligrams:

_____

_____

Are you currently taking any blood thinner medications: YES or NO

PHARMACY NAME: _____ **LOCATION:** _____

ALLERGIES: YES or NO: Circle any allergies:

Codeine	Demerol
Iodine	Penicillin
Sulfa	Novocain

Others _____

Have you had any previous surgeries: Yes or NO: If yes, please list.

_____

FAMILY MEDICAL PROBLEMS: _____

Do you smoke or vape nicotine? Yes or NO

Do you drink: None ____ Socially ____

Alcohol____ Rarely ____ Daily ____

Beer____ **Wine**____ Occasionally ____

Height: _____ Shoe Size: _____ Weight _____

Signature of Patient or Guardian: _____ **Date:** _____

The information stated above is true and correct to the best of my knowledge.

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NOTICE OF PRIVACY PRACTICES

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

SUMMARY

This notice contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with your health information. For further information, there is a copy of Patient Rights & Responsibilities posted in the reception area.

DISCLOSURE OF HEALTH INFORMATION

Your health information will be disclosed to treat you or to assist other health care providers in treating you. We will also disclose your health information to obtain payment for our services or to allow insurance companies to process claims for services rendered by our office or other health care providers. Lastly, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students. Except as stated in more detail we will not use or disclose your health information without your written authorization.

In the following circumstances we may disclose your health information without your written authorization:

1. for certain limited research purposes.
2. for purposes of public health safety
3. to government agencies for purposes of audits, investigation and other oversight activities
4. to government authorities to prevent child abuse or domestic violence
5. to the FDA to report product defects or incidents
6. to law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
7. when required by court order, search warrant, subpoena or otherwise required by the law

PATIENT RIGHTS

As a patient of Parkwood Podiatry Associates, LLC you have the following rights:

1. to have access to and / or a copy of your health information
2. to receive an accounting of certain disclosures we have made of your health information
3. to request restrictions as to how your health information is used or disclosed
4. to request that we amend your health information
5. to receive notice of our privacy practices

If you would like to submit a comment or complaint about our privacy practices or if you believe that your rights have been violated, please send a letter outlining your concerns to:

Privacy Officer
Parkwood Podiatry Associates, LLC
2500 Starling Street Suite 301
Brunswick, GA. 31520

Patient's Name: (please print) _____ **Date:** _____

Patient/Guardian Signature: _____ **Date:** _____

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Date: _____

Patient Name: _____

DOB: _____

SS#: _____

I, _____, authorize the following listed physicians to obtain and or release any requested information to and or from Parkwood Podiatry Associates, LLC. This information may include but is not limited to: any office notes, labs, appointment information, patient demographic and insurance information.

*Dr. _____ *Dr. _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

I authorize Parkwood Podiatry Associates, LLC to leave a message on my voicemail.

(Circle Choice) Yes or No

In addition to myself, I also authorize the following person(s) to discuss and obtain any of my medical information from Parkwood Podiatry Associates, LLC regarding treatments or account information. **(Circle Choice) Yes or No**

*If yes, please list: *Name: _____ Relation: _____ DOB: _____

Signature of Patient or Responsible Guardian: _____ Date:_____

Witness (Office Staff): _____ Date: _____

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