WELCOME TO OUR OFFICE!

PATIENT INFORMATION RECORD

Date CHART #

Patient's Name Marital Status

Home Address CITY OR TOWN ZIP

Home Phone Date of Birth Age

Name of Employer Occupation

Business Address CITY OR TOWN ZIP Business Phone

SPOUSE/RELATIVE Relation

EMERGENCY CONTACT PH #

PHYSICIAN INFORMATION

PRIMARY DOCTOR

DATE OF LAST VISIT

HEALTH INSURANCE INFORMATION

PRIMARY Insurance Company	SECONDARY Insurance Company
Name	Name
Telephone No.	Telephone No.
Group I.D. No.	Group I.D. No.
Cert. or Policy No.	Cert. or Policy No.
Name of Insured	Name of Insured
Relation to Patient	Relation to Patient

SEE REVERSE SIDE

Milford Foot Care LLC
990 Bridgeport Ave. Milford, CT 06460
TEL 203/878-2642 FAX 203/882-0718
http://milfordfootcare.com

MEDICATION LIST

Name _____ DOB _____

MEDICATION	DOSE	HOW OFTEN	PRESCRIBING DOCTOR

PRIMARY CARE
Doctor _____ Phone # _____

Pharmacy _____

ALLERGIES _____

Immunizations (record the date/year of the last does taken, if known)

Tetanus _____

Pneumonia vaccine _____

Flu vaccine _____

_____**height** _____**weight**

X _____
SIGNATURE

DATE _____

OVER

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

E-MAIL ADDRESS _____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ____/____/____

MILFORD FOOTCARE, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

MILFORD FOOTCARE, LLC

PATIENT AGREEMENT

_____ (Initial) **CURRENT INSURANCE CARD/PHOTO ID:** All patients must present a current insurance card and a valid photo identification card (state issued driver's license or identification card), to be scanned into the patient medical record. If the patient being treated is a minor, the parent or guardian, financially responsible, must be present and must present insurance card and photo identification. ***If a valid insurance card is not presented before your visit, payment is due in full when the service is provided.***

_____ (Initial) **APPOINTMENTS:** ***24 hours notice*** must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee may then be added to your account. The fee charged for missing or failing to cancel an office visit is ***$25***. This fee is not covered by insurance and will be billed directly to the patient or guarantor.

_____ (Initial) **REFERRALS:** If your insurance plan requires a referral from your primary care physician (PCP), it is your responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, you will be required to pay for your visit or reschedule your appointment once a referral can be obtained.

PAYMENT POLICIES

Your insurance policy is a contract between you and your insurance company. We are not responsible for, or in control of what services your insurance company will pay for, or the amount your insurance company will reimburse for services rendered.

_____ (Initial) **CO-PAYMENTS:** By contract, we must collect your insurance carriers designated specialist co-pay. Co-payment is due at the time of service. Please be prepared to pay the ***current co-pay*** at each visit. If you do not pay we will bill you for the co-pay once. If we need to bill more than once, there will be a ***$5 administrative fee*** for statement processing added to your account.

_____ (Initial) **DURABLE MEDICAL DEVICES:** When appropriate, we will submit a bill to your insurance carrier for items such as cast boots, diabetic shoes, orthotics, etc.. You acknowledge that in the event your carrier does not cover those items, you are responsible for payment.

_____ (Initial) **PATIENT RESPONSIBLE CHARGES:** If you do not have insurance coverage or you are purchasing non-covered services or items, payment is due in full at the time of service. Payment may be made by cash, personal check or credit card. We accept all major credit cards.

_____ (Initial) **NSF CHARGE:** ***$35*** will be charged if a personal check is returned due to "insufficient funds" and a different form of payment will be expected for past balances and future services rendered.

Name: _____ **Signature:** _____

Dated: _____