SUMMERLIN FOOT & ANKLE NEW PATIENT REGISTRATION

PLEASE PRINT

PATIENT INFORMATION				
Last Name	First Name	MI	Social Security Number	
Address	City	State	Zip	Date of Birth
E-mail	Home Phone	Cell Phone		Sex
Employer/School	Work Phone	Marital Status S M W D		Name of Spouse

RESPONSIBLE PARTY STATEMENT		
AS A RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.		
RESPONSIBLE PARTY NAME	RESPONSIBLE PARTY SIGNATURE	TODAY'S DATE

REFERRAL INFO: Internet, Magazine, Newspaper, Physician, Family, Friend, Educational Presentation, Other		
Name	Address	Phone

PRIMARY CARE PHYSICIAN			
Last Name	First Name	Address	Phone

PARENT/GUARDIAN INFORMATION IF PATIENT IS A MINOR - OR IN CASE OF EMERGENCY			
Last Name	First Name	Home Phone	Work Phone
Address	Cell Phone	Relationship to patient	

PRIMARY INSURANCE COMPANY			
Insurance Company Name	ID Number		
Group Number	Subscriber Name	Relationship to patient	
Subscriber Date of Birth	Subscriber ID # or SSN	Sex	

SECONDARY INSURANCE COMPANY			
Insurance Company Name	ID Number		
Group Number	Subscriber Name	Relationship to patient	
Subscriber Date of Birth	Subscriber ID # or SSN	Sex	

COLLECTION POLICY

CO-PAYS & REASONABLE ESTIMATES OF DEDUCTIBLES WILL BE COLLECTED AT THE TIME OF SERVICE. PRIMARY AND SECONDARY INSURANCES WILL BE BILLED RESPECTIVELY. IF THERE IS A PATIENT BALANCE AFTER THE INSURANCE COMPANIES HAVE PROCESSED THE CLAIM, A STATEMENT WILL BE SENT TO YOU. REFERRAL TO CREDIT BUREAU CENTRAL WILL ONLY OCCUR AFTER 3 NOTICES WITH NO PAYMENT OR PAYMENT PLAN SET UP.

ASSIGNMENT AND RELEASE

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN, and I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES AND EXPENSES THAT ARE NOT DIRECTLY PAID BY THE INSURANCE COMPANY. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED IN THE PROCESSING OF CLAIMS REGARDING SERVICES RENDERED BY THIS PHYSICIAN TO ME.

Signature: _____ **Date:** _____

SUMMERLIN FOOT AND ANKLE
Patient Record

Name _____ Age _____ Sex _____ Shoe size _____

Date _____ Height _____ Weight _____ Occupation _____

REASON FOR VISIT _____

Personal History

Have you ever had: Please circle all that apply

ANXIETY/ DEPRESSION
ANEMIA
ARTHRITIS (IF YES, LIST TYPE):
ASTHMA
EMPHYSEMA/ COPD
BACK PROBLEMS
BLOOD CLOTS/ DVT/ PE
CANCER (IF YES, LIST TYPE):
CHRONIC PAIN
DIABETES
ECZEMA, DERMATITIS, PSORIASIS
EPILEPSY/ SEIZURES
EXCESSIVE BLEEDING
GOUT
HEART ATTACK
HEART DISEASE
CONGESTIVE HEART FAILURE
ATRIAL FIBRILLATION
HEPATITIS A B C
LIVER PROBLEMS
HIGH BLOOD PRESSURE
HIV/ AIDS
KIDNEY DISEASE/ DIALYSIS
PERIPHERAL ARTERIAL DISEASE
POLIO
PREGNANT (CURRENTLY)
RHEUMATIC FEVER
STROKE/TIA
THYROID DISORDER
TUBERCULOSIS
ULCERS
OTHER: _____

Drug Allergies: _____

Medications: (please specify name)

Social History:
Tobacco: (packs per day x how long?)
Alcohol: _____
Drug Abuse: _____
Have you required a blood transfusion: _____

Surgical Procedures: (please specify date and type)

Family History:	Father	Mother	Bro/Sis
Age			
Cancer			
Diabetes			
Heart Disease			
High BP			
Age of death			
Cause			

SUMMERLIN FOOT & ANKLE

Randy L. Gubler, D.P.M, John Cade, D.P.M., Leonard Franklin D.P.M
3320 North Buffalo Dr., Suite 107
Las Vegas, NV 89129

Thank you for choosing us as your healthcare provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask the receptionist.

You must understand the following:

1. Your insurance policy is a contract between you, your employer, and the insurance company. Our relationship is with you, not your insurance company.
2. All services are provided to you with the understanding that you are responsible for their cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire with the staff prior to treatment. Please be aware that not all services are a covered benefit in all insurance policies. You are responsible for knowing, per your insurance plan on what services are or are not covered. Fees for these services, along with any unpaid deductible and co-payment are due prior to the time of treatment. You are responsible for these amounts.
3. You are responsible for knowing your insurance benefits. Does your insurance company require a referral? What facilities participate in your plan? If we can be of assistance, please let us know. We are sure we can answer most questions regarding your insurance.
4. We will bill the insurance information you provided to us as a courtesy, but you are still ultimately responsible for payment of any services you receive. We will also follow up on your claim. If, however, your insurance does not respond to us within 60 days of claims submission, the amount will become your responsibility and you will have to follow up with your carrier for payment of the claim.
5. If your medical claim has not been paid by your insurance company and you have contacted them with no results, there is recourse for you. The Nevada Department of Business and Industry has established an insurance division to receive questions, complaints and comments from the consumers in Nevada concerning healthcare plans. Their address is 555 E. Washington Ave., Las Vegas, NV 89101 and phone number is (702) 485- 4000.
6. If you are a Medicare beneficiary by Federal Law we are required to collect 20% of the "Medicare Assignment" portion which the Federal Government does not pay. Medicare will only pay 80% of the assigned amount after your deductible has been paid. Again, if you have a financial problem or question, please contact the Billing Department.
7. If there are no payments made on the account after 30 days, there will be a 1.5% interest charge each month until the balance is paid in full.
8. If it becomes necessary that your account must be turned over to collections you will be notified first. You are responsible for all collection and legal fees.
9. Returned checks subject to a $25.00 fee. Initial here _____
10. There is a no show fee of $25.00/office visit. Initial here _____

As a recipient of Federal financial assistance, Summerlin Foot & Ankle does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, gender, religion, color, national origin, disability, age or any unlawful reason in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by Summerlin Foot and Ankle directly or through a contractor or any other entity with which Summerlin Foot and Ankle arranges to carry out its programs and activities.

We do understand any temporary problems one may have at the time of the visit. We encourage you to make us aware of this prior to the treatment, so we can assist you in any way regarding your balance. OUR MAIN CONCERN IS OUR PATIENTS WELL BEING.

_____ _____

Signature of Patient or Guardian Date

Patient Privacy Directive

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPPA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

- Please provide us with the **PHONE NUMBER(S) that we, or an automated service, may leave a message regarding appointments:**

  _____

- Please provide us with the **PHONE NUMBER(S) that we, or an automated service, may leave messages regarding treatments and/or test results**:

  _____

- Please provide us with the **NAME(S) that we may speak to regarding your appointments**:

  _____

- Please provide us with the **NAME(S) that we may speak to regarding your treatments and/or test results**: _____

- Please provide us with the **NAME(S) that we may speak to regarding your billing:**

  _____

- Please provide an **EMAIL ADDRESS that this office may communicate health information to you**:

  _____

- Please provide a **cell phone number that we may TEXT health information to you**:

  _____

- Please indicate if we can **MAIL lab and other results to the address indicated in your file**:

  _____ yes _____ no

You must inform us in writing of any changes in your directives. I acknowledge that everything above is accurate.

_____ _____

Printed Name Date of Birth

_____ _____

Signature Date

Relationship to patient if necessary _____

AWKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature