WELCOME TO JASON SNYDER PODIATRY P.C.

Thank you for selecting us for your foot and ankle care. To better help us meet your needs, please fill out this form COMPLETELY in ink. If you have any questions or need any assistance, please do not hesitate to ask us. We are always happy to help. Welcome again to our practice!

PATIENT INFORMATION

PLEASE PRINT

PATIENT NAME: _____ **MALE / FEMALE** (Circle one)
LAST FIRST MI

BIRTHDATE:_____ AGE: _____ **SOC SEC#**: _____

PHONE#(H)_____(W)_____CELL: _____E-MAIL:_____

HOME ADDRESS:
NO. & STREET: _____ **CITY**: _____ **ST**: ____ **ZIP**: _____

WHO IS FINANCIALLY RESPONSIBLE FOR YOUR MEDICAL BILLS? _____RELATIONSHIP_____

EMERGENCY CONTACT:_____**PHONE#**_____RELATIONSHIP_____

Are you covered under health insurance benefits by your employer? YES / NO
Are you covered under health insurance benefits by your spouse or parent's employer? YES/ NO

Primary Insurance Company:_____ Secondary Insurance Company: _____
Primary Insurance Policy #: _____ Secondary Insurance Policy #: _____
Primary Insurance Group #: _____ Secondary Insurance Group #: _____
Effective Date of Insurance: _____ Effective Date of insurance: _____
Name of Insured: _____
Relationship to Patient: ____ Self ____Spouse ____Parent

Name of Primary Care Provider:_____ **Date of Last Visit with PCP**:_____
Have you ever had a pneumonia vaccine? (Pneumovax): Yes / No
Pharmacy: _____

Medical Problems: _____

Medication: (Attach list if you have one)	**Dose**	**How often taken**

Surgery / Type	**Date**

Hospitalization Reason	**Date**

Allergies?	**Type:**

Social History

Marital Status:	○Single	○Married	○Partnered	○Separated	○Divorced ○Widowed
Use of Alcohol:	○ Never	○ Occasionally	○ Often	○History of use	
Use of Tobacco:	○ Never	○ Occasionally	○ Often	○History of use	
Use Recreational Drug:	○ Never	○ Occasionally	○ Often	○History of use	
Occupation:		**On feet:** ○10%	○25%	○50%	○75% ○100%

Family History

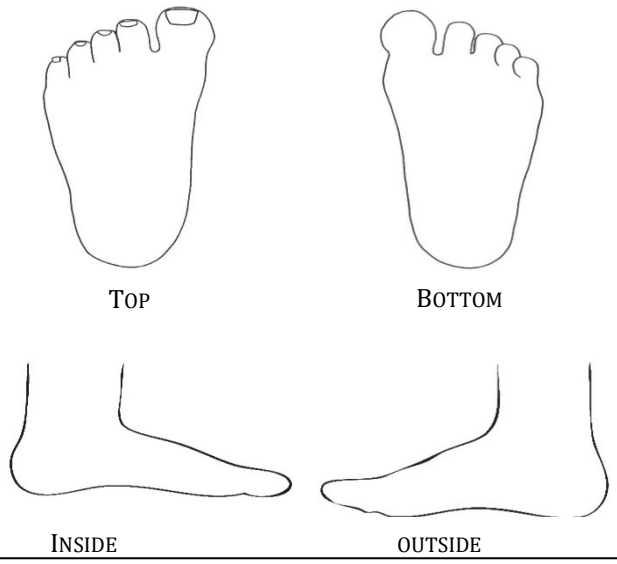
○ Diabetes ○ Cancer ○Heart Disease ○ High Blood Pressure ○Stroke ○Coronary Artery Disease
○Thyroid Disease ○ Rheumatoid Arthritis ○Other:_____
Relation: _____

Your Visit

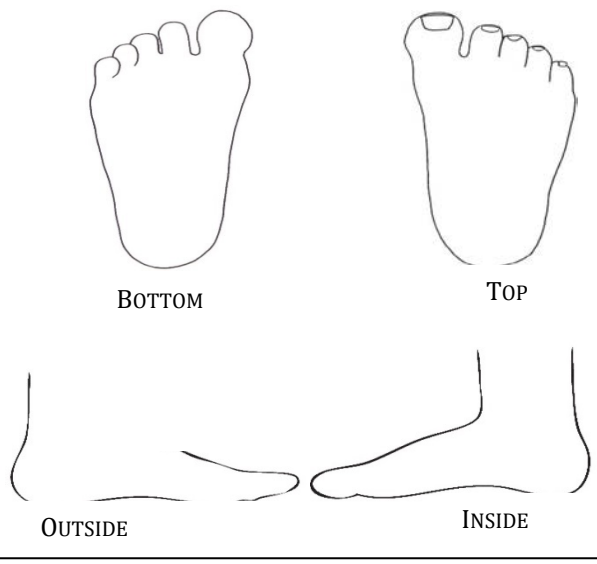
What brings you to our office today? _____

Where is the pain/problem located? Please mark on the pictures below.

Left Foot



Right foot



To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be hazardous to my health. I understand that it is my responsibility to inform the doctor and staff of any changes in my medical status.

Signature: _____ **Date:** _____

Print Name: _____

OFFICE POLICY AND HIPPA

Thank you for choosing us for as your health care provider for your foot care needs! We are committed to your treatment being successful. The following is a statement of our financial policy, which we request you read and sign prior to any treatment.

* **IT IS YOUR RESPONSIBILITY TO PROVIDE THIS OFFICE WITH CURRENT INSURANCE INFORMATION ON EACH DATE OF SERVICE.**
* **ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE.**

I understand that I am responsible to turn over any reimbursement checks sent to my household by my insurance company within **five business days**.

I am aware that should I fail to sign the reimbursement checks from my insurance company over to Jason Snyder Podiatry P.C. and either mail or deliver them to the office within the allotted time period, I will be responsible for the **full** cost of my visit.

I further agree to cancel my appointment should the need arise at least 24 hours in advance. Non-adherence to this policy may result in a fee of twenty-five dollars, especially if repeated instances occur. I also agree to cancel any surgery appointments at least 72 hours in advance. Non-adherence to this policy may result in a fee of seventy-five dollars and/or I may not be able to reschedule my surgery in the future. If documented medical reasons result in cancellation of your surgery, this policy will not apply for a particular surgical date if the documentation is provided. This policy allows us to better serve our patients and allow fairness to others.

HIPPA

You authorize the release of medical or other information necessary to process my insurance claims. With this form, you have been provided with a full copy of HIPPA rights and a copy is available should you request one. Signing below acknowledges receipt of these policies.

I have read the Office Policy and my HIPPA rights. I understand and agree to this policy.

SIGNATURE: _____

PRINT NAME: _____

DATE: _____

FINANCIAL POLICY

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Regarding Non-Participating / Out of Network Insurance Plans:
As a courtesy to you, we will be happy to submit your insurance claim for you if you provide us with complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Therefore, the balance is your responsibility. We will accept insurance payments at usual and customary rates. The insured party is responsible for any copays or deductibles as contracted by your insurance company.

Regarding Participating/Contracted HMO, PPO and POS Insurance Plans:
Our office participates with many insurance policies. It is your responsibility to verify participation with your individual plan. You are responsible for notifying your primary care provider if you need a referral. You must have a valid insurance referral with you at the time of service. In the event that your insurance changes to a plan that we are not participating providers, refer to the above paragraph.

Regarding Medicare:
We do accept assignment, however if you do not have a supplemental insurance (secondary), **the 20% co-insurance is your responsibility.** If you have a supplemental insurance, we will be happy to bill them for you.

Usual and Customary Rates:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area as determined by practices within the geographical area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates if we are non-participating with your insurance.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

***I have read the Financial Policy. I understand and agree to this policy*.**

SIGNATURE: _____

PRINT NAME: _____

DATE: _____