Bucks County Podiatry

Suzanne Phillips, D.P.M.

1073 Second Street Pike, Richboro, PA 18954
Phone: 267-288-5103 • Fax: 267-288-5108
www.BucksCountyPodiatry.com

PODIATRIC REGISTRATION AND HISTORY

1. PATIENT INFORMATION

DATE	WHO IS RESPONSIBLE FOR THIS ACCOUNT?		
LAST NAME	FIRST NAME	MIDDLE INIT.	RELATIONSHIP TO PATIENT (IF ACCOUNT HOLDER DIFFERS)
STREET ADDRESS		CITY / STATE / ZIP CODE	
HOME PHONE ( )	CELL PHONE ( )		
BIRTHDATE	SOCIAL SECURITY #	SEX ☐ M ☐ F	EMAIL ADDRESS
MARITAL STATUS ☐ Single ☐ Married ☐ Widowed ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years			
PATIENT EMPLOYER / SCHOOL	EMPLOYER / SCHOOL ADDRESS	EMPLOYER / SCHOOL PHONE ( )	
SPOUSE'S NAME	SPOUSE'S BIRTHDATE	SPOUSE'S EMPLOYER	
WHOM MAY WE THANK FOR REFERRING YOU?			

2. IN CASE OF EMERGENCY, CONTACT

EMERGENCY CONTACT NAME	RELATIONSHIP	HOME PHONE ( )	WORK / CELL PHONE ( )

3. INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	GROUP #	IS PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ Yes ☐ No
SUBSCRIBER'S NAME	SUBSCRIBER'S BIRTHDATE	SUBSCRIBER'S SOCIAL SECURITY #
RELATIONSHIP TO PATIENT	SECONDARY INSURANCE COMPANY (IF APPLICABLE)	SECONDARY GROUP #

4. INSURANCE ASSIGNMENT AND RELEASE & MEDICARE AUTHORIZATION

Insurance Assignment and Release: I certify that I have insurance coverage with _____ (Name of Insurance Company/ies) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare / Medigap Authorization: I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____ (Name of Doctor or Clinic) for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian, or Personal Representative	Date	Relationship to Beneficiary

Please Print Name of Beneficiary, Guardian, or Personal Representative

5. PODIATRIC HISTORY

WHAT IS THE CHIEF COMPLAINT FOR WHICH YOU CAME TO BE TREATED?	WHEN DID THE COMPLAINTS BEGIN?
YOUR OCCUPATION	CIGARETTE / TOBACCO USE ☐ Yes ☐ No Years smoked: _____
HAVE YOU EVER BEEN TO A PODIATRIST BEFORE? ☐ Yes ☐ No If yes, Name: _____ Last Visit: _____	IS THERE ANY PERSONAL OR FAMILY HISTORY OF DIABETES? ☐ Yes ☐ No
ATHLETIC ACTIVITIES IN WHICH YOU PARTICIPATE (PLEASE LIST AND INDICATE FREQUENCY)	

FOOT & LOWER EXTREMITY CONDITIONS (PRESENT OR PAST)

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Ankle Pain	☐	☐	Cramps/Numbness in Feet/Legs	☐	☐	Heel Pain	☐	☐
Athlete's Foot	☐	☐	Flat Feet	☐	☐	Ingrown Toenails	☐	☐
Bunions	☐	☐	Foot or Leg Cramps	☐	☐	Plantar Warts	☐	☐
Corns and Calluses	☐	☐	Swelling in Ankles or Feet	☐	☐			

6. MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following conditions:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS / HIV	☐	☐	Ear Problems	☐	☐	Psychiatric Care	☐	☐
Allergies to Anesthetics	☐	☐	Epilepsy	☐	☐	Radiation Treatment	☐	☐
Allergies to Medicine/Drugs	☐	☐	Eye Problems	☐	☐	Rash	☐	☐
Anemia	☐	☐	Fainting	☐	☐	Respiratory Disease	☐	☐
Angina	☐	☐	Foot or Leg Cramps	☐	☐	Rheumatic Fever	☐	☐

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Arthritis	☐	☐	Gout	☐	☐	Shortness of Breath	☐	☐
Artificial Heart Valves/Joints	☐	☐	Headaches	☐	☐	Sinus Problems	☐	☐
Asthma	☐	☐	Heart Disease	☐	☐	Special Diet	☐	☐
Back Problems	☐	☐	Hemophilia	☐	☐	STD	☐	☐
Bleeding Disorders	☐	☐	Hepatitis or Jaundice	☐	☐	Stroke	☐	☐
Cancer	☐	☐	High Blood Pressure	☐	☐	Swelling in Ankles / Feet	☐	☐
Chemical Dependency	☐	☐	Kidney Problems	☐	☐	Swollen Neck Glands	☐	☐
Chest Pain	☐	☐	Liver Disease	☐	☐	Tired Feet	☐	☐
Chronic Diarrhea	☐	☐	Low Blood Pressure	☐	☐	Tuberculosis	☐	☐
Circulatory Problems	☐	☐	Neurologic Disease	☐	☐	Ulcers	☐	☐
Diabetes	☐	☐	Neuropathy	☐	☐	Varicose Veins	☐	☐
Phlebitis	☐	☐	Weight Loss, Unexplained	☐	☐			

ARE YOU NOW, OR HAVE YOU BEEN, UNDER ANY OTHER DOCTOR'S CARE FOR ANY REASON OVER THE PAST TWO YEARS?

☐ Yes ☐ No If yes, please explain: _____

FAMILY PHYSICIAN	LAST VISIT DATE
SURGERIES YOU HAVE HAD	**HOSPITALIZATIONS (OTHER THAN LISTED SURGERIES)**

7. MEDICATIONS, ALLERGIES & TREATMENT CONSENT

CURRENT MEDICATIONS (PRESCRIPTIONS, OTC, VITAMINS)

Pharmacy Name(s): _____

Pharmacy Phone(s): ( ) _____

Do you take oral contraceptives? ☐ Yes ☐ No

KNOWN ALLERGIES (CHECK ALL THAT APPLY)

☐ Adhesive / Tape
☐ Anticoagulant Therapy
☐ Aspirin
☐ Codeine
☐ Demerol
☐ Iodine
☐ Local Anesthetics
☐ Novocaine
☐ Penicillin
☐ Seafoods
☐ Sulfa
Other: _____

Treatment Consent: I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____ _____

Signature of Patient, Parent, Guardian, or Personal Representative | Date | Relationship to Patient

_____

Please Print Name of Patient, Parent, Guardian, or Personal Representative

HIPAA CONSENT TO RELEASE OF MEDICAL RECORDS

In order to facilitate the continuity of my medical care and treatment, I consent and authorize my physicians and authorized agents and employees of **Bucks County Podiatry** and other hospitals, practices, clinics, and providers affiliated with Bucks County Podiatry to use and/or disclose my personal health information and to release medical records relating to my inpatient or outpatient care in their control and possession—including, but not limited to, progress notes, discharge summaries, operative notes, results of lab tests, radiology reports, and consultations and other information about my Medical Records—to other Systems Providers and to the Department of Public Welfare and/or its assigned agencies (if I am receiving services and payment under the Medical Assistance Program), my insurance company, family physician, other providers of follow-up care, family members or friends involved in my medical care, and to any other person or entity identified below:

AUTHORIZED PERSON / ENTITY (OTHERS)	ADDRESS / CONTACT INFORMATION

I understand that the information from my Medical Record may be used and/or disclosed by Bucks County Podiatry to request authorization, bill, or obtain payment for my care and treatment from insurance companies, managed care companies, government programs, or other responsible parties and their agents or auditors, and I consent to the use and disclosure of my medical information for such purposes. I understand that information from my Medical Record may be used for educational, administrative, or approved purposes.

I understand that the release of information about my treatment for drug abuse, alcohol abuse, or mental illness, and HIV or AIDS information will require me to sign a separate consent form. The law permits certain disclosures of medical records and information to those responsible for paying for your medical care and to those providing current and follow-up medical care.

I release my physicians, and their employees, agents, and representatives from legal responsibility or liability for the disclosure of my Medical Records and the information contained therein. Once my Medical Record is disclosed, it may no longer be protected by federal and/or state privacy laws.

I give this consent voluntarily and with full understanding of its nature.

I acknowledge that I have received the **Bucks County Podiatry Notice of Privacy Practices**, which explains in greater detail the uses and/or disclosures of my personal health information described above.

Patient / Authorized Representative Signature _____ Date _____

Printed Name _____ Relationship (if not patient) _____

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing **Bucks County Podiatry** as your healthcare provider. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure that payment is made in full for the services you receive.

1. **Ultimate Financial Responsibility:** You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, copayments, co-insurance amounts, or any amount not covered by your health insurance.
2. **Insurance Claim Submission:** All insurance claims will be submitted by our office to your insurance carrier. If you have multiple insurers, it is your responsibility to provide our office with that information at the time of your visit.
3. **Credit Card on File:** Bucks County Podiatry will request a credit card to keep in a secure location with **Heartland Payment Systems**. All information is kept confidential and **SECURE**.
4. **Billing & Past-Due Balances:** Once your insurance claim is processed, and if there is any outstanding payment still due (deductible, co-insurance, copay, denial), our office will send a bill to the address that you provide to us. You will have **30 days** to make payment on your account. **After 30 days, the credit card that is kept on file will be processed with the outstanding balance.** If the credit card on file is declined and the payment cannot process, a **30% FEE** will be added to all past-due accounts and balances will be forwarded to a collection agency.

By signing below, I acknowledge that I have read, understood, and agree to the terms of the Patient Financial Responsibility Statement.

X Signature of Patient or Parent of Minor _____ Date _____

Printed Name of Patient or Parent of Minor _____