Graser Podiatry & Bunion Surgery Inst

NEW PATIENT REGISTRATION

FILL OUT COMPLETELY

___Male ____Female Marital Status: __M__ S__ W__ D

Name: _____ DOB: ____ /____ /_____ SSN# _____ /_____ / _____

Address:_____ City: _____ State: _____ Zip: _____

Mailing Address (if different from above): _____

Primary contact Ph: _____ Cell:_____ Other: _____

Employer/Occupation: _____ Ph: _____

Primary Care Dr: _____ LAST VISIT: _____

Emergency contact: _____ Relation: _____ Ph: _____

Email:_____ Pharmacy Info: _____

How did you hear about us: _____ PCP _____ WEB _____ WALK IN _____ FB _____OTHER

May we leave _____TEXT _____VOICE messages/Appt reminders _____ CELL Ph _____EMAIL _____HOME Ph

INSURANCE- BILLING ORDER

PRIMARY INS: _____ Member ID#: _____ Group #: _____

SECONARY INS: _____ Member ID#: _____ Group #: _____

IF YOU ARE UNSURE PLEASE CALL MEDICARE COORDINATION OF BENEFITS PH: (855) 798-2627

INSURED POLICY HOLDER (If other than Patient)

Name: _____ Relation:_____ DOB:_____ SSN: _____

Preferred Statement delivery method (Mailed, Emailed, Texted link) #1_____ #2_____

AUTHORIZATION TO RELEASE AND ASSIGNMENT OF BENEFIT

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS OR TO SEEK FURTHER TREATMENT. I ALSO ACKNOWLEDGE THAT I AM AWARE THAT A NOTICE OF PRIVACY PRACTICES IS AVAILABLE TO ME. UPON REQUEST AND THAT CHANGES TO MY NOTICE MAY OCCURE BUT I MAY ASK FOR A REVISED COPY OF THE NOTICE. I HEREBY AUTHORIZE GRASER/MEDINA PODIATRY & BUNION SURGERY INST TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED BY DR. ROBERT E. GRASER, OR BY HIS ORDER. I REQUEST THAT PAYMENTS FROM MY INSURANCE COMPANY BE PAID DIRECTLY TO: DR ROBERT E GRASER DPM, PA
DBA: GRASER PODIATRY & BUNION SURGERY INST / OR THE PARTY WHO ACCEPTS ASSIGNMENT-ASSOCIATES
I CERTIFY THAT THE INFORMATION I HAVE REPORTED REGARDING MY INSURANCE COVERAGE IS CORRECT. THIS AUTHORIZATION MAY BE REVOKED BY EITHER ME OR MY INSURANCE AT ANY TIME IN WRITING.

SIGNATURE **X** _____ DATE ____/____/_____

MEDICAL HISTORY

MEDICAL FOOTWARE: HEIGHT _____ WEIGHT _____ SHOE SIZE _____ SHOE WIDTH_____

Please describe your present foot problem: _____
_____
_____
_____

How long have you had this foot problem: _____
_____
_____
_____

Have you been treated in the past for this problem? ____ NO ____Yes *explain below*

WHAT TYPE: _____
WHEN: _____
WHERE: _____

___ Gout	___ Varicose Veins	___ Kidney Problems	___ Tuberculosis
___ Anemia	___ Tumors/Growth	___ Bleeding Diffuclty	___ Hypertension
___ Cancer	___ Healing Problems	___ Muscular Disorder	___ Cholesterol
___ Epilepsy	___ Swelling Feet	___ Shortness of breath	___ Hay Fever
___ Stroke	___ Stomach Ulcer	___ Rheumatic Fever	___ Heart Trouble
___ Arthritis	___ Liver Problems	___ Circulation Problems	

___ OTHER _____

Are you diabetic: ___ NO ___ YES If Yes, What Type: _____

Family history of Diabetes : ___ NO ___ YES Diagnosed with Neuropathy: ___ NO ___ YES

MEDICATION ALLERGIES: ___ NO ___ YES

___ Penicillin	___ Lidocaine	___ Sulfa Drugs	___ Adhesive Tapes
___ Codeine	___ Anesthetics	___ Iodine	___ Other Antibiotics
___ Foods	___ Other (Specify) _____		

***** REACTION***_____**

Are you currently taking PRESCRIPTION Medications: ___ NO ___ YES *please list below*

1- _____ 5- _____
2- _____ 6- _____
3- _____ 7- _____
4- _____ 8- _____

FINANCIAL AND APPOINTMENT POLICY

BILLING AND INSURANCE

We electronically bill all our claims. Due to new and increasing Ins subsidiaries, We do NOT paper bill any claims. Although we may be contracted by the "Parent Organization", this does NOT guarantee automatic contractual agreement with subsidiary Insurances. It is ALSO Patient responsibility to verify with your Ins about your particular coverage such as referrals, authorizations, deductibles, copay/co-ins prior to your visit, due to delays in reporting information by system softwares.

- **All co-pays, deductibles, co-insurances, and previous balances are the financial responsibility of the patient and due at check in. If you are unsure of any, please contact your Health Insurance plan BEFORE your office visit. These will be due prior to rendering service**
- All balances due are payable immediately. If you are unable to make payment in full, please speak to the billing office to make arrangements. ALL DELINQUENT ACCOUNTS WILL BE SENT TO COLLECTIONS
- Insurance is filed as a courtesy to our patients. If your Insurance cannot be verified, you will be considered a "self-pay" patient and payment in full will be expected at each visit. No insurance will be filed on services over 30 days old.
- INSURANCE MUST BE VERIFIED AT THE TIME OF APPOINTMENT. IT IS FULL PATIENT RESPONSIBILITY TO REPORT ALL CHANGES OF INSURANCE AND DEMOGRAPHICS TO US **BEFORE ANY OFFICE VISIT/ SCHEDULING**. FAILURE TO DO SO WILL RESULT IN CARE DELAY AND FULL FINANCIAL RESPONSIBILITY.
- ANY CLAIM DENIALS DUE TO INCORRECT INFORMATION GIVEN BY THE PATIENT OR FAILURE TO UPDATE INFORMATION ON FILE WITH US WILL BE FULL PATIENT RESPONSABILITY. IF UNSURE OF WHO YOUR PRIMARY PAYOR IS, YOU NEED TO CALL YOUR YOUR HEALTH INSURANCE DIRECTLY

X _____

MEDICARE- We accept assignment on Medicare claims. Medicare patients will be expected to pay their deductible (if not met) or 20% co-payment on the service date. For Patients with traditional Medicare, It is important that you give us the correct DATE LAST SEEN of your Primary Care Provider for billing purposes. Medicare requires this information on all claims for reimbursement on **Podiatry services** rendered to you. **WE ARE REQUIRED TO ASK THIS ON EVERY VISIT.** Failure to provide us with the correct information may result in Patient financial responsibility.

X _____

HOSPICE- Patients on Hospice are required to notify the office prior to the scheduled Appointment. Failure to do so will result in full Patient financial responsibility

X _____

DISRUPTIVE BEHAVIOR-

Our office has a zero tolerance for intimidating or disruptive behaviors such as discrimination, physical, sexual or verbal abuse/ harassment which includes shouting, rude, demanding or demeaning behavior, negative personal comments, threats, foul language, loud angry tones, false allegations or other false accusations. It is considered unacceptable regardless to whom it is directed and will be cause for termination of the Patient relationship.

X _____

We electronically bill all Insurance.Please CALL your Health Insurance to verify network participation and for verification on referral or authorization requirements.

MISSED APPOINTMENTS

Due to a growing wait-list we are enforcing our Appointment policies.
ANY Appt change requires a full 24-hour (business day) notice. Please note that failure to notify our office **at least 24 hours in advance will be considered a NO-CALL /NO-SHOW and will be subject to rescheduling and/or charged a fifty dollar ($50) penalty fee**; this will not be covered by your insurance company. The Patient will be responsible for payment in full before next scheduled appointment. Repeated missed appointments will result in dismissal from our practice.

X _____

TARDIES

We understand that delays can happen however we must try to keep the other patients and doctors on time. Patients running late must call the office to verify that they can still be seen. If we can, there might be a waiting time. If we are unable and need to reschedule, this will be considered a No-Show, penalized with a penalty fee and would then need to be re-scheduled.

X _____

APPT REMINDERS /CONFIRMATIONS

As a "courtesy" to our Patients we try our best to personally call each and everyone to remind/confirm Appt's. Unfortunately this is not always possible, therefore we rely on our Automated system to make these calls and/ or send out texts. Ultimately, it is the Patients responsibility to remember the date and time of their Appt. Due to our growing wait list we are required to confirm Appt's at least 24hrs of the scheduled Appt time.

UNCONFIRMED APPT's ARE SUBJECT TO BE SEEN OR CONSIDERED A WALK-IN

****It is important we have correct/ up to date methods of contact, PATIENTS WITH INNACURATE/ UNVERIFIABLE INFORMATION ON FILE WILL BE REMOVED FROM OUR SCHEDULE 24HRS BEFORE THE SCHEDULED TIME OF THE APPT ****

X _____

SURGERY

Due to large block of times needed for surgery, last minute cancellations can cause problems and added expenses for the office. If surgery is not canceled at least 48 hours in advanced, you may be fined and you will be charged a two hundred-dollar ($200) fee; this is **will not** be covered by your insurance company **an**d the Patient will be responsible for full payment before next scheduled appointment.

X _____

MEDICAL RECORDS AND FORMS

We strongly adhere to HIPAA regulations to maintain the confidentiality of our patients' medical records. Patient consent is required before records can be released to any entity. Our office will charge a fee for Records, forms, and narrative letters and due upon receipt. Please allow 3-7 business days for completion.

BY SIGNING BELOW, I CONFIRM THAT I HAVE READ, UNDERSTOOD AND AGREED TO THE OFFICE POLICIES

SIGNATURE _____ **DATE** ____/____/_____