Medina Valley Podiatry Associates

Dr Robert E Graser DPM, PA

☐ Hondo Tx
☐ Devine Tx

NEW PATIENT REGISTRATION

M__ F__ Marital Status: M__ S__ W__ D__

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

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

Primary contact Ph: _____ Cell:_____ Other: _____

Employer/Occupation: _____ Ph: _____

PCP FULL NAME: _____ **LAST VISIT**: _____

Emergency contact: _____ Relation: _____ Ph: _____

Email:_____ Pharmacy Info: _____

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

INSURED POLICY HOLDER (If other than Patient)

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

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

Ph: _____ Relation: _____

INSURANCE

PRIMARY Insurance Co. Name: _____

Member ID#: _____ Group #: _____ Ph: _____

SECONARY Insurance Co. Name: _____

Member ID#: _____ Group #: _____ Ph: _____

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.

SIGNATURE X _____ DATE: ____/____/____

I HEREBY AUTHORIZE **MEDINA VALLEY PODIATRY ASSOCIATES** 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 **DBA: MEDINA VALLEY PODIATRY ASSOCIATES / DR ROBERT E GRASER DPM, PA** (OR THE PARTY WHO ACCEPTS ASSIGNMENT).

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

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____ Please describe your present foot problem:

_____

_____

_____

_____

How long have you had this problem:

_____

_____

_____

_____

Have you had previous treatment for this problem: YES* ____ NO ____

* If YES, by whom and where? _____

Do you have any of the following medical conditions?

___ Gout	___ Arthritis	___ Kidney Problems	___ Tuberculosis
___ Anemia	___ Varicose veins	___ Bleeding Difficulty	___ Hypertension
___ Cancer	___Tumors/Growth	___ Cholesterol	___ Muscular Disorder
___ Epilepsy	___ Healing Problems	___ Liver Problems	___ Shortness of breath
___ Stroke	___ Swelling Feet	___ Heart Trouble	___ Hay Fever
___ Fainting	___ Stomach Ulcer	___ Rheumatic Fever	___ other _____

Do you have Diabetes? ___ YES ___ NO
Is there a history of Diabetes in your family? ___ YES ___ NO

Do you have any allergies to medications? ___ YES ___ NO

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

Are you currently taking any medications? ___YES ___ NO If so, please list them._____

_____

_____

Pharmacy: _____ Location: _____ Ph: _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND REQUEST PAYMENT OF BENEFITS, GOVERNMENT OR OTHER TO BE MADE TO: **DBA: MEDINA VALLEY PODIATRY ASSOCIATES / DR ROBERT E GRASER DPM, PA**

I HEREBY GIVE PERMISSION TO **MEDINA VALLEY PODIATRY ASSOCIATES** RENDERING PROVIDERS TO EXAMINE AND ADMINISTER TREATMENT AFTER CONSULTATION AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY CONDITION.

_____	_____	_____/_____/_____
NAME (PRINT)	SIGNATURE	DATE

FINANCIAL POLICY

ALL PAYMENTS ARE EXPECTED AT TIME OF SERVICE

INSURANCE:

Insurance cards and valid ID MUST be scanned at every office visit. Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable co-payments, deductibles and coinsurance for participating insurance companies. Co-payments will not be billed to you and will be required prior to the medical visit. We accept cash, personal checks (In State only) and credit/debit cards. There will be a $25 charge for returned checks and patient will be required to pay by cash or credit card for future visits.

We bill participating Insurance companies as a courtesy to you. If for ANY reason we have not received payment from your insurance company within 45 days of the date of service, you will be responsible for ALL charges. All outstanding balances must be paid in full before future appointments**. IT IS FULL RESPOSIBILTY OF THE PATIENT TO REPORT ALL CHANGES OF INSURANCE AND DEMOGRAFICS TO US BEFORE ANY OFFICE VISIT/SCHEDULING.** Failure to do so will result in patient care delay and full financial responsibility.

X _____

MEDICARE:

We accept assignment on Medicare claims. Medicare patients will be expected to pay their deductible (if not met) and 20% co-payment. If at the time of service, you provide a Medicare card and have an HMO replacement with a primary care provider, you will be responsible for the services provided to you.

X_____

SELF-PAY/NO INSURANCE:

GRASER PODIATRY & BUNION SURGERY INSTITUTE has a discounted fee schedule for Patients who do not have Healthcare insurance or cannot provide satisfactory proof of insurance. If Self-Pay patients are on a Payment Plan (subject to approval) and fail to make a payment or arrangements before scheduled payment/office visit then the Self-Pay Discount will be forfeited and the patient will be obligated and required to pay the full charges. All patients are required to pay 100% of charges at the time of initial visit.

X_____

REFERRAL:

A referral is NOT a guarantee of payment therefore if for any reason your visit is denied, it is the patients full responsibility to pay for the office visit. It is your responsibility to make sure the referral is valid and pre-approved at the time of visit or it will be patients responsibility for all charges.

Initials: _____

_____ _____ _____/_____/_____

NAME (PRINT) SIGNATURE DATE

CANCELLATIONS, LATE & NO SHOW POLICY

DOCTOR APPOINTMENTS:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit due to a seemingly "full" appointment book. **If an appointment is not cancelled at least 24 hours in advance you will be charged a "No-Show" twenty-five-dollar ($25) fee**; this will not be covered by your insurance company. Patient will be responsible for full payment before next scheduled appointment.

X_____

LATE APPOINTMENTS:

We understand that delays can happen however we must try to keep the other patients and doctors on time. Patients arriving 15 minutes past their scheduled time without notifying our office will be considered a no-show (missed appointment) and will have to reschedule and/or pay a no show fee due before the next appointment.

X_____

SURGERY:

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office. If surgery is not cancelled at least 24 HRS in advance you will be charged a one hundred-fifty-dollar ($150) fee; this is will not be covered by your insurance company**.** Patient will be responsible for full payment before next scheduled appointment.

X_____

ACCOUNT BALANCES

We will require that patients with self-pay balances pay their account balances to zero (0) prior to receiving services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can. review their account and concerns.

Patients with balances over $100 must pay balance or make payment arrangements with our office prior to next scheduled appointment

_____	_____	_____/_____/_____
NAME (PRINT)	SIGNATURE	DATE

Protected Health Information Release Form

***Note: Completion of this form is optional. To be valid, this form must be filled out COMPLETELY, including the type of information you are granting us permission to share.**

Name: _____ Date: _____

I give permission to **MEDINA VALLEY PODIATRY ASSOCIATES** to release the following protected health records and/or information about me (check all that apply) to the following Individual (s).

_____ Scheduling/Cancelling/ appointment information
_____ Medical information, including my symptoms, diagnosis, medications, and treatment plan.
_____ Lab/test results
_____ Billing and payment information
Other: _____

Verbal	Written	Name	Phone	Relationship to Patient

I understand that I may cancel this permission at any time (In writing), but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

This authorization expires:
When I cancel it in writing OR on _____ (specify date)
If no expiration date is specified, this authorization will remain in effect until **MEDINA VALLEY PODIATRY ASSOCIATES** receives written notice to cancel it.

_____ I decline permission to release ANY protected health records and/or information.

_____
SIGNATURE

OFFICE POLICIES

MEDINA VALLEY PODIATRY ASSOCIATES strive to provide our patients with quality care and the highest standards of professionalism. Our office policies help us to maintain and achieve our goals.

APPOINTMENTS

Please call the office and we will be happy to schedule an appointment for you. A referral is required from the primary care provider or treating physicians if you are a new patient with a Managed Care Plan. For established patients, please contact our office to schedule an appointment. If your insurance requires you to have a referral from your primary care doctor, please call our office to make sure you have one on file. Patients with missing or no referrals will be responsible for the office visit charges.

All cancellations or reschedules of follow-up appointments require a 24-hour notice. Please note that failure to cancel appointments, or "no-show," for three appointments may result in dismissal from the practice.

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 insurance company, law office or any other entity. Our office will charge a fee for Records, forms and narrative letters due upon receipt. Please allow 3-5 business days for completion. Please fill out our Medical Release Form and fax to 830-253-0007.

X_____

BILLING AND INSURANCE

Always bring your insurance card to your appointment and notify our staff with any changes of your information. Please be prepared to pay your copayment, coinsurance, and deductible prior to your appointment. We accept most health insurance; please see the Health Insurance Plans we are in-network with or **CALL** your Health Insurance for verification.

- 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.
- Failure to give a 24-hour notice or repeated missed appointments or reschedules will also result in a $25.00 fee. The fee will be collected prior to your being seen for your next appt.
- All balances due from the patient are payable immediately. If you are unable to make payment in full, please speak to the billing office to make financial arrangements.
- Insurance is filed as a courtesy to our patients. Please bring your card with you to each visit. If you have insurance but cannot produce a valid card, you will be considered a "self-pay" patient and payment in full will be expected at each visit until a valid card is produced. No insurance will be filed on services over 45 days old.

X_____

_____ _____ ____/____/____

NAME (PRINT) SIGNATURE DATE .

PATIENT COPY