

Graser Podiatry & Bunion Surgery Inst.

17 Old San Antonio Rd. Ste. #201 Boerne, TX. 78006/ Ph (830) 253-0008/ Fax (830) 253-0007

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: _____
SECONDARY 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 **GRASER PODIATRY & BUNION SURGERY INSTITUTE** 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: GRASER PODIATRY & BUNION SURGERY INSTITUTE -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?

- | | | | |
|-----------------------------------|---|--|--|
| <input type="checkbox"/> Gout | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Bleeding Difficulty | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Tumors/Growth | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Muscular Disorder |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Healing Problems | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Swelling Feet | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> 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

- | | | | |
|--|--|--------------------------------------|---|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Adhesive Tapes |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Foods | <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Other Antibiotics | <input type="checkbox"/> 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: GRASER PODIATRY & BUNION SURGERY INSTITUTE - DR ROBERT E GRASER DPM, PA**

I HEREBY GIVE PERMISSION TO **DR ROBERT E. GRASER** 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

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 Graser Podiatry & Bunion Surgery Institute 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 Graser Podiatry & Bunion Surgery Institute receives written notice to cancel it.

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

SIGNATURE

OFFICE POLICIES

Graser Podiatry & Bunion Surgery Institute strives 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