Kevin J. Powers, DPM

1791 West 3rd St., Bloomington, IN 47403

Welcome To Our Practice

Date: ___________________

Please provide your email:____

Patient: _________________________________ Address: ____

City: ____________________________________ State: ________________________ Zip: __________________

Sex M: ___ F: ____ Age: _____ Birth Date: _______________ Marital Status: __________________________

Patient SS#: _________________________________ Family Doctor: ___________________________________

Employer: ____________________________________ Employer Phone: _________________________________

Spouse's Name: ______________________________ Birthdate: _______________ SS#: _________________

Spouse's Employer: ____

Who referred you to our office?

Doctor: (name ______________________________) Newspaper:_______________Yellow Pages:_____________

Friend/Relative: (name ________________________) Website: _______________________________________

Social Media: _____________________________ Other: ____

PHONE NUMBERS

Home:______________________ Work:_____________________(ext. ______________) Cell: _________________

Best time and place to reach you: (Time)_________________ (Place)___________________________________

In case of emergency

Name: _________________________________ Relationship: _____________________________________

Home Phone:___________________________ Work Phone: _____________________________________

INSURANCE

Relationship to patient:____

Who is responsible for this account?____

Insurance Company:_________________________________ Name of Insured:___________________________

Birthdate:____ SS#:_______________________________________

Is patient covered by additional insurance? YES NO

PLEASE SIGN ON BACK

Please provide your email:____

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

PATIENT NAME:____

"I request that payment of authorized insurance benefits be made either to me or on my behalf to Kevin J. Powers, D.P.M. For any services furnished me by that physician. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits payable for related services."

I understand that information will be released to:

- Billing department of the physician and/or practice

I understand that my information, under certain circumstances may be released for one of the following reasons:

- Other health care professionals in order to coordinate my care or treatment
- Insurance adjuster if my claim is a work or motor vehicle injury
- Employer, if my claim is related to a work injury
- Attorney, if my claims are in a litigation process
- Health insurance carrier, for chart audit reason, and for claim payment

I understand that my physician and/or his staff and the billing office will not release any information to myself or family members over the phone without verification of my identity in order to comply with privacy regulations. I also understand that my physician and his/her staff and the billing office will maintain the utmost respect for privacy. However, I also understand that there are physical constraints such as noise and the ability for others to overhear information, as well as the potential for confidential information to be disclosed after it has been provided to others from the clinical billing office.

By my signature, I state that I have read, understand, and agree to this Authorization and Release.

______________________________	______________________________
Patient or Guardian Signature	Witness
______________________________	______________________________
Date	Date

A 2ND SIGNATURE IS REQUIRED FOR YOUR SUPPLEMENTAL INSURANCE

Insurance Name:____

"I request that payment of secondary insurance benefits be made either to me or on my behalf to my provider of services for any services furnished to me by the provider of service. I authorize any holder of primary insurance information about me to release to my secondary insurer, named above, any information needed to determine these benefits payable for related services."

______________________________	______________________________
Patient or Guardian Signature	Date

Please provide your email:______________________________

KEVIN J. POWERS, D.P.M.

MEDICAL HISTORY

Name:______________________________ Age:__________ Date:____________

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Current Medications | **Dosage**

______________________ ______
______________________ ______
______________________ ______
______________________ ______
______________________ ______
______________________ ______
______________________ ______
______________________ ______
______________________ ______
______________________ ______
______________________ ______

Please list medication allergies **(Very Important)**

____
____
____

Height: ____________ Weight: ________

Reason for today's visit:

____
____
____
____

Current or Previous Illness

Illness	**Yourself**	**Family**
High Blood Pressure	Y or N	Y or N
Angina	Y or N	Y or N
Heart Failure	Y or N	Y or N
Heart Rhythm Disorders	Y or N	Y or N
Bloods Clots	Y or N	Y or N
Tuberculosis	Y or N	Y or N
Asthma	Y or N	Y or N
Other Lung Disorders	Y or N	Y or N
Diabetes	Y or N	Y or N
Ulcers	Y or N	Y or N
Hepatitis	Y or N	Y or N
Kidney Disorders	Y or N	Y or N
Mood Disorders	Y or N	Y or N
Cancer	Y or N	Y or N
Stroke	Y or N	Y or N
Tobacco use	Y or N	Y or N
(If yes, number of packs per day ______)		
Alcohol use	Y or N	Y or N
(If yes, number of drinks per day ______)		
Other______________________________		

Date of Injury:______________________ OR date symptoms began:________________

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PREVIOUS SURGERIES/HOSPITALIZATIONS

	Date		**Date**
Tonsilectomy	______________	Heart Sugery	______________
Appendectomy	______________	Spinal Sugery	______________
Gall Baldder	______________	Trauma/Injury	______________
Hysterectomy	______________	Other	______________
Hernia	______________	______________________	
		______________________	

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I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or member of the office staff for assistance.

______________________________ ______________________________

Patient or Guardian Signature Date

Please provide your email:____

FINANCIAL RESPONSIBILITY

I understand that the physician's billing staff will file all claims for services rendered to my insurance carrier.

I, however, acknowledge that I am responsible for any balances that may be due to the physician because of:

- Co-insurance or co-pay amounts
- Yearly deductible
- Non covered services
- Out of network charges
- Terminated coverage
- Exhausted auto benefits
- Denied workers compensation claim
- No insurance coverage
- No referral obtained from primary physician
- Failure to respond to insurance carrier correspondence
- Failure to respond to coordination of benefits inquiry

I understand that I will receive a statement for any balance due, after the claim has been processed by my carrier. I understand and am agreeable that the balance of my statement will be paid in full to the physician within 30 days.

If I am unable to pay the entire amount (applies to amounts of $150.00 or more), I am responsible to immediately, on receipt of statement, call the billing office at 800-322-4606 to arrange a monthly payment plan, for no less than $50.00 per month ($100 for balances over $500).

I understand that failure to pay my balance or arrange payments and follow that payment agreement may result in Collection Agency action.

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $50.00 per missed visit. Please help us serve you better by keeping scheduled appointments.

_______________________________________ _______________________________________

Signature of patient/responsible party Date