**WELCOME TO OUR PRACTICE**
**Kevin J. Powers, D.P.M.**

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**Please provide your email** ____________________

DATE ________________

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 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 ______________________________________________

***IN CASE OF EMERGENCY***

NAME ________________________________ RELATIONSHIP ____________________________

HOMEPHONE ___________________________ WORK PHONE ______________________________

## INSURANCE

RELATIONSHIP TO PATIENT ___________________________________________________________

WHO IS RESPONSIBLE FOR THIS ACCOUNT? ____________________________________________

INSURANCE COMPANY ___________________________ **NAME OF INSURED** ____________________

**BIRTH DATE** ____________________ **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, and other errors that may occur, which may cause inadvertent dissemination of 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***

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**INSURANCE NAME** ______________________________

"I request that payment of secondary insurance benefits be made either to me or on my behalf to my provider of service 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.

______________________________ ______________________________

Signature Patient or Guardian 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 |
| Blood 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** |
|---|---|
| Tonsillectomy | ________________ |
| Appendectomy | ________________ |
| Gall bladder | ________________ |
| Hysterectomy | ________________ |
| Hernia | ________________ |
| Heart Attack | ________________ |

| | **Date** |
|---|---|
| Heart surgery | ________________ |
| Spinal surgery | ________________ |
| Trauma/Injury | ________________ |
| Other | ________________ |

______________________________

______________________________

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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.***

**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 @ 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