PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/___/___

PATIENT NAME: _____, _____ _____
LAST FIRST MI

DATE OF BIRTH: ___/___/___ AGE: _____ SEX: M F SSN:_____-_____-_____ MARITAL STATUS: _____

HOME ADDRESS: _____CITY/STATE: _____ ZIP:_____

EMPLOYER: _____ ADDRESS: _____

CITY/STATE: _____ ZIP: _____ PHONE: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (_____) _____-_____ YES NO

WORK PHONE #: (_____) _____-_____ YES NO

CELL PHONE #: (_____) _____-_____ YES NO

E-MAIL (REQUIRED): _____

PRIMARY LANGUAGE: _____ RACE: _____ETHNICITY:_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) _____-_____

PRIMARY PHYSICIAN: _____PHARMACY: _____ LOCATION: _____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

_____ YES NAME(S) _____

_____ NO _____

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

WHO REFERRED YOU TO US? _____GOOGLE _____PHONEBOOK _____INSURANCE CO. _____DOCTOR
_____FRIEND/FAMILY _____OTHER _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

INSURED NAME: _____ DATE OF BIRTH: _____ SSN: _____

EMPLOYER _____ID# _____ GROUP # _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (_____) _____-_____

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		Date
Tonsillectomy	_____	Heart surgery	_____
Appendectomy	_____	Spinal surgery	_____
Gall bladder	_____	Trauma/Injury	_____
Hysterectomy	_____	Other	_____
Hernia	_____		_____
Heart Attack	_____		_____

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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** _____

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- There are certain surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- Unless cancelled at least 24 hours in advance, there will be a charge for missed appointments at the rate of $50.00, per missed visit. Please help us serve you better by keeping scheduled appointments.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party _____

Printed Name of Patient/Responsible Party _____

Date: _____

_____ Patient initials to indicate copy received.

Revised January 2019

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEITS

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 rendered to me by Dr. Kevin Powers or Dr. Tracy Lee. I authorize any holder of medical information about me to release to my insurance company and it agents any information needed to determine benefits payable to related services."

I understand that information will be released to:

- The billing department of the physician and/or practice.

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

- Other healthcare 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 claim(s) is in a litigation process
- Health insurance carrier for chart audit reason and for claim payment

I understand that my physician and/or his/her staff and the billing office will not release any information to me 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 signing below, I state that I have read, understand, and agree to this authorization and release.

_____ _____

Patient or Guardian Signature Witness

_____ _____

Date Date

A second 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 for any services rendered to me by the provider. I authorize any holder of primary insurance information about me to release to my secondary insurer, named above, any information or documentation needed to determine the benefits payable for related services."

_____ _____

Signature of Patient or Guardian Date