Date: _____

Name: _____ _____ **Gender:** M F TG
(First) (Middle) (Last) (Suffix or title)

Date of Birth: _____/_____/_____ **S.S.N.** _____-_____-_____ **Marital Status:** S M D W

Street & Apt #: _____

City: _____ **State:** _____ **Zip:** _____

Phone Numbers: **Preferred contact number?**

Home: _____ ☐

Cell: _____ ☐

Work: _____ ☐

E-mail: _____

Emergency Contact Person:

Name: _____
Relationship: _____
Phone: _____

Is this person your Care Giver? Y or N

Patient Data

Race (check applicable): ☐ *Asian* ☐ *Black or African American* ☐ *American Indian or Alaska Native* ☐ *White* ☐ *Native Hawaiian or other Pacific Islander* ☐ *Other* ☐ *Unknown/undetermined*

Ethnicity (check applicable): ☐ *Hispanic/Latino* ☐ *Non-Hispanic/Non-Latino*

Preferred language (check applicable): ☐ *English* ☐ *Spanish* ☐ *Other* _____

Primary Physician: _____ **Phone:** _____

Address: _____

Pharmacy Name & Phone: _____

The Responsible Party is the person who will be responsible for any unpaid balances after insurance payments.

Name: _____ _____
(First) (Middle) (Last) (Suffix or title)

Street: _____

City: _____ **State:** _____ **Zip:** _____

Preferred Phone Number: _____

Date of Birth: _____/_____/_____ **S.S.N.** _____-_____-_____

Relationship to Patient: _____

Power of Attorney Information:
Name: _____
Addr: _____
Phone: _____

Responsible Party

The Insurance Subscriber is the person who is the "holder" of the insurance policy covering the patient.

Name: _____ _____
(First) (Middle) (Last) (Suffix or title)

Street: _____

City: _____ **State:** _____ **Zip:** _____

Preferred Phone Number: _____

Date of Birth: _____/_____/_____ **S.S.N.** _____-_____-_____

Relation to Patient: ☐ *Self* ☐ *Spouse* ☐ *Parent* ☐ *Other* **Employer:** _____

Insurance

	Insurance Carrier	Policy Number	Group Number
Primary			
Secondary			

FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT

The Responsible Party whose signatures appear below agrees as follows:

- The Doctor(s), Associate Doctor(s), and staff of the Medical Practice, hereby referred as DOCTOR, are authorized to medically treat the patient named on this form and to exchange past, present and future medical information with the patient and other medical care givers for the purpose of enhancing and promoting the continuity of care for the patient.
- The Responsible Parties agree to pay for all fees and charges for supplies and services and treatment that are incurred by the patient per the terms of this agreement. All charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date. The Responsible Parties remain, jointly and severally, financially responsible to the patient unless the DOCTOR receives their notification in writing to the contrary. If the patient is currently a minor, their guarantee is continuing even after the patient reaches the age of majority.
- Not all services and/or fees are covered by the benefits plan of the Responsible Parties' health care insurance (i.e.: insurance company, HMO, employer or government benefits provider) hereafter referred to as the PLAN. Therefore, the Responsible Parties agree to pay for all deductibles, co-payments, non-covered services and any portions of covered services not paid in full by the PLAN and understand that such **payments are due at the time of services or immediately upon presentation of the bill.**
- If any account balance should remain unpaid for 60 days and the DOCTOR refers the account to a collection agency or attorney for collection, the Responsible Parties agree to pay the costs of collection and that such fees and costs may be added to the account balance. In a legal action between the parties to this agreement to collect an unpaid balance due for medical services rendered, the prevailing party shall be entitled to recover reasonable attorney's fees and costs.
- Payments will not be delayed or withheld, regardless of any lawsuits, liens, insurance coverage, the pendency of claims thereon or the outcome of medical treatment. All proceeds from the PLAN are assigned to the DOCTOR where applicable. As they are responsible for all charges the Responsible Parties will assist the DOCTOR in every way to collect payments from the PLANS to the extent their help is required.
- The Responsible parties acknowledge receipt of the DOCTOR'S Office Policy that included the terms of the financial Agreement & Authorization for Treatment. There are no other agreements, promises, representations or warranties, expressed or implied. The provisions of these agreements shall not be changed or modified except for an instrument in writing signed by the parties hereto.

INSURANCE AGREEMENT: DIRECT PAYMENT ASSIGNMENT & INFORMATION RELEASE:

- We hereby name the Doctor(s) and/or Medical Practice given below, hereafter referred to as DOCTOR, as my/our assignee. I/We instruct my/our health care benefits plan administrator, i.e.: insurance company, HMO, employer or government benefits provider, hereafter referred to as the PLAN, to pay DOCTOR directly for all professional and medical services provided by the DOCTOR, through means of electronic funds transfer (EFT), or by check(s) made payable and mailed to the DOCTOR **REMIT TO: BUXMONT FOOT & ANKLE CARE CENTERS - 399 NORTH YORK ROAD - WARMINSTER, PA 18974** or if my current policy prohibits direct payments to doctor(s), the I/We hereby instruct and direct the PLAN to make out all checks payable to me/us in care of the DOCTOR as given directly above. THIS IS A DIRECT ASSIGNMENT OF MY/OUR RIGHTS AND BENEFITS UNDER THE POLICY.
- I/We grant the DOCTOR a limited Power of Attorney to sign my name(s) in order to deposit and negotiate any payment received from the PLAN and apply the funds received toward my/our outstanding balance. These payments will not exceed my/our indebtedness to the above designated DOCTOR. I/We agree to promptly pay any remaining balance sue on all professional service charges over and above payment(s) from the PLAN. This assignment shall remain in effect until cancelled in writing by the DOCTOR.
- A photocopy of this agreement or electronic facsimile thereof shall be considered as effective as the original.
- I/We understand that additional information about me/us will be needed by the DOCTOR and the PLAN to determine and communicate what services and benefits are covered by the PLAN and to submit or process a claim for payment on services rendered and for the DOCTOR to collect all fees owed for those services. Therefore, for the purposes of obtaining payment for services rendered, I/We give to the DOCTOR, the PLAN, the Health Care Financing Administration, their agents and/or any other holder of information about me/us, authorization to release and/or exchange medical, billing and collection information.
- There will be a fee of $25 for any bounced check.
- **THERE WILL BE A CHARGE OF $25 FOR A MISSED APPOINTMENT UNLESS OUR OFFICE IS NOTIFIED 5 HOURS IN ADVANCE (This is not covered by insurance)**

IN THE EVENT THAT THE CARE RENDERED RESULTS IN A MALPRACTICE LEGAL ACTION:

1. The grievance shall be subject to voluntary binding arbitration by a panel to be selected by the American Arbitration Association.
2. Arbitration shall take place in BUCKS County, the site of the primary office of Bux-Mont Foot & Ankle Care Center.
3. If by agreement of the parties, or by court order, the legal action is remanded to the courts, Item #2 will still pertain.
4. In preparation of the plaintiff's legal case, the plaintiff agrees to use as an expert witness only a licensed practicing board certified Podiatrist certified by the American Board of Podiatric Surgery; to the collateral source rule, which states that a recovery is limited by prohibition of recovery of an award for losses covered by any other form of insurance, award or public program; to periodic pay-outs of any award to the plaintiff on a reasonable scale to be decided by the arbitrators; to pay any and all fees incurred by the defendant and/or his insurance carrier in defending the case in the event that the defendant prevails in this action.

A SIGNATURE ON THIS FORM SHOWS THAT YOU COMPLETELY UNDERSTAND AND ACCEPT OUR POLICIES

X_____ X_____ X_____

RESPONSIBLE PARTY NAME (Please Print) RESPONSIBLE PARTY SIGNATURE DATE

Bux-Mont Foot & Ankle Care Centers

399 N. York Road
Warminster, Pa 18974
215-672-3222

11 Friends Lane, Suite 102
Newtown, Pa 18940
215-860-8866

FAX 215-672-6634

NOTICE OF PRIVACY PRACTICES

Health Information Uses and Disclosures:
In our medical practice we routinely record, use and disclose your health information in order to treat you and to assist other health care providers in treating you. We also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services that we or other health care providers give you. Finally, we may need to use and disclose your health information for certain limited business operational activities such as practice management, training, licensing, accreditation and quality assessment.

Other Uses and Disclosures Not Under Your Control:
We may need to disclose your health information without your written authorization in the following situations:

- To contact you by telephone, fax and regular or electronic mail to remind you of your appointment or to respond to your questions;
- For purposes of public health and safety, such as to the FDA to report product defects or incidents;
- To government agencies for purposes of their audits, investigations and other oversight activities;
- For research purposes of a limited nature in a limited manner;
- For providing benefits under Workmen's Compensation;
- To the military and Department of Veterans Affairs;
- To law enforcement authorities to assist in apprehending criminal offenders;
- To government authorities for prevention of child abuse or domestic violence;
- When required by law, search warrants, subpoenas or court orders;
- To federal, state and local law enforcement authorities involved in security services, as required.

Uses and Disclosures Controlled by You:
We will not use or disclose your health information without prior written authorization, except for those uses we have stated above.

Your Patient Rights:
As a patient you have the following rights:

- To receive a Notice of Privacy Practices;
- To obtain access to and/or a copy of your health information;
- To request that we communicate with your confidentially, by reasonable, alternative means;
- To request restrictions on how we handle or disclose your health information;
- To request amendments to your health information;
- To request and receive an accounting of certain disclosures which we made of your health information.

Should you have any questions, concerns or complaints regarding our privacy practices, now or in the future, please contact our office.

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was provided with a copy of the Notice of Privacy Practices from Bux-Mont Foot & Ankle Care Centers for me to keep and that I have read (or had the opportunity to read if I so choose) and understand the Notice. This acknowledgement is requested per government statute.

X_____ _____

Print Name | Print Name of Responsible Party (if applicable)

X_____ X_____ _____

Signature of Patient/Responsible Party | Date | Relationship to Patient

Medical History Form

Name: _____ **Date:** _____

How did you hear about our office? _____

Primary Physician: _____ **Date Last Seen:** _____

Current Medications, Vitamins and Over-the-Counter: ☐ **None**

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies to Medications, Dyes or other Substances: ☐ **None**

_____ _____ _____

_____ _____ _____

_____ _____ _____

Operations & Hospitalizations: (List year and type of operation or diagnoses)

_____ _____ _____

_____ _____ _____

Past Medical History

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Anemia
- ☐ Heart Disease
- ☐ Chest Pain or tightness
- ☐ Shortness of Breath
- ☐ Swollen ankles
- ☐ Palpations
- ☐ Lightheadedness
- ☐ Frequent Urination
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ _____

Do you currently smoke tobacco? Y or N

Have you ever smoked tobacco? Y or N

- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Persistent cough
- ☐ T.B.
- ☐ Hay Fever
- ☐ Abdominal discomfort
- ☐ Indigestion
- ☐ Nausea / Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Weight change
- ☐ Gout
- ☐ Sleep Problems
- ☐ _____

Amount of tobacco use daily? _____

Number of years smoking? _____

- ☐ Gall bladder disease
- ☐ Bruise easily
- ☐ Thyroid Disease
- ☐ Headaches
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Low back problems
- ☐ Numbness of legs/feet
- ☐ Skin Diseases
- ☐ Blood Disorders
- ☐ STD
- ☐ Anxiety
- ☐ Depression
- ☐ Diabetes
  - o Oral _____
  - o Insulin _____

What year did you quit smoking? _____

FAMILY HISTORY

- ☐ Cancer _____
- ☐ Hypertension_____
- ☐ Diabetes_____
- ☐ Strokes _____
- ☐ Mental Disorder _____
- ☐ Heart Disease _____
- ☐ Kidney Disease_____
- ☐ Other _____