

PATIENT LEGAL NAME & ADDRESS:

First _____ Last _____

Address _____

City _____ State _____ Zip _____

Home Ph: _____

Cell Ph: _____

Work Ph: _____

Circle Best Number to Reach You During the Day

May we leave a detailed voice message for you? Y N

Date of Birth: _____

SSN: _____

Marital Status: _____

Race: White Black Hispanic Other

Ethnicity: Hispanic Non-Hispanic

Language: English Spanish Other

Email Address: _____

PRIMARY CARE PHYSICIAN:

Name: _____

EMERGENCY CONTACT:

Name: _____

Ph: _____

Relationship to patient: _____

PRIMARY INSURANCE:

Policy Holder Name _____

Insured DOB _____

Relationship to Insured _____

Address Same as Patient Y N

Insurance Name _____

ID # _____

Grp # _____

SECONDARY INSURANCE:

Policy Holder Name _____

Insured DOB _____

Relationship to Insured _____

Address Same as Patient Y N

Insurance Name _____

ID # _____

Grp # _____

OFFICE POLICIES:

Protected Health Information and Notice of Privacy Practices

Nashville Family Foot Care, PLLC has my permission to discuss personal information regarding my care, treatment or Financial obligations with **the following people:** _____

Authorization will remain in effect until revoked in writing. I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read and understand the Notice.

Assignment and Release

I, the undersigned, certify that I or my dependent have insurance with the previously stated insurance carrier and assign to Nashville Family Foot Care, PLLC all benefits, if any, otherwise payable to me for services rendered. I further authorize the use of this signature on all insurance submissions. I also consent to treatment for my condition as directed by my physician.

Financial Policy

I understand that all account balances not paid within 30 days of initial billing will incur a billing charge of 1.5% per month until collected. I also understand that I am responsible for all collection or legal fees associated with the collection of my account to include court cost, attorney cost, or cost of a collection company contracted by Nashville Family Foot Care, PLLC. These fees will be in addition to the balance on my account and are due and payable by me.

All returned checks will be re-deposited once as a courtesy to our patients. If on the second deposit the check is returned the amount of the check will be added back to the patient's account and a non-sufficient funds fee of \$25.00 will be charged to the patient. The balance including NSF fee must be paid in full by either cash or money order within 10 days of receipt of the returned check on the second occurrence.

Referral Policy

I understand that if my insurance company requires that prior authorization or a referral is required in order for benefits to be considered that obtaining the referral or prior authorization is my sole responsibility.

Consent for Prescription History

PHARMACY NAME & LOCATION

I consent to allow Nashville Family Foot Care to access my prescription history when integral to my care or deemed medically necessary.

Signature of Patient/Legal Guardian

Date