

BARE FOOT CARE SPECIALIST
3485 Atlanta Highway Flowery Branch, GA 30542
Phone 770-531-9222 Fax 770-531-9020

Patient Information

Date _____

Patient Name _____

Last name

First Name

Middle Initial

Mailing Address _____

City

State

Zip

Social Security Number _____ Date of Birth _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Email _____

____ Married ____ Widowed ____ Single ____ Minor (**Person Responsible for the Minor**) _____

In case of an emergency, contact: Name _____ Phone (_____) _____

Insurance Information

Who is responsible for this account? _____

Name of 1ry Insurance _____ 2ry Insurance _____

A COPY OF YOUR CURRENT INSURANCE CARD(S) WILL BE SAVED AS PART OF YOUR FILE AND WILL BE USED TO BILL YOUR INSURANCE COMPANY(IES) FOR ANY COVERED MEDICAL SERVICES.

All Insurance Assignment and Release (REQUIRED). Please initial all that apply and sign at the bottom

I certify that I have insurance coverage with the above listed insurance(s) and assign directly Bare Foot Care Specialists, all insurance benefits, if any, otherwise payable to me for services rendered. I authorize release to the indicated insurance company(ies) any medical information needed to determine these payments for related services.
_____ initial

I hereby agree to pay Bare Foot Care Specialists, in a timely fashion, for any and all services rendered which may or may not be covered by my insurance. This includes any co-payment, deductible and/or insurance payments that I may receive as a result of services rendered. **Should my account not be paid in a timely manner I understand that I will be held responsible for any further collection and/or attorney fees.** An additional fee of \$25.00 will be imposed in the event of a returned check for insufficient funds. _____ initial

In the event that my medical insurance **is terminated, changed, cancelled, or reinstated** after the date when services were provided, I understand and certify that I will be responsible for the **entire cost** of the medical expenses that are billed to my insurance company. I understand that I will then be responsible for contacting my insurance company and attempt to be compensated for all or any of the cost of my medical care, previously or currently being denied for lack of coverage. _____ initial

Signature of Beneficiary or Guardian

Print name of Beneficiary or Guardian

Date

Podiatric History

What is the main reason for which you came to be treated? (include foot, ankle, knee, thigh, and hip complaints.)

Is there any *personal* or *family history* of diabetes? ____ Yes ____ No **WHO?** _____

List any other medical problems in the family: _____

Women Only – Are you currently pregnant? ____ Yes ____ No

Athletic activities in which you participate (please list and indicate frequency) _____

Please circle any foot problems you have now or have had in the past.

Ankle Pain Athlete's Foot Bunions Corns/Calluses Cramps/Numbness in Foot/Legs Flat Feet Foot Ulcers Gout Hammertoes
Heel Pain Ingrown Toenails Neuromas Plantar Warts Swelling in Ankles/Feet Tired Feet

NAME OF YOUR MEDICAL DOCTOR/PRIMARY CARE PHYSICIAN: _____ **PHONE #:** (____) _____

EXACT DATE YOU SAW YOUR MD/PCP: _____ **WHO REFERRED YOU TO US?** _____
***** **(MEDICARE REQUIREMENT)*******

Mark (x) If you currently have or have had in the past any of the following:

- AIDS Appendicitis Arthritis Asthma Bleeding Disorders Blood Clots Breast Lump Cancer Cataracts
- Chicken Pox Chemical Dependency Circulation Problems Diabetes Emphysema Epilepsy Glaucoma Heart Disease
- Hepatitis Herpes High Blood Pressure High Cholesterol HIV positive Kidney Disease Liver Disease Measles
- Migraine Headaches Multiple Sclerosis Mumps Neuropathy Pacemaker Pneumonia Polio Prostate Problem
- Rheumatic Fever Scarlet Fever Stroke Thyroid Problems Transplants Tuberculosis Ulcers Venereal Disease

Other Medical Problems which you have: _____

Surgeries

Please list all previous surgeries: _____

Medications

List all medications you are currently taking: _____

Pharmacy Name: _____ Phone (____) _____

ALLERGIES to medications or substances: _____

Health Habits

Mark (x) which you use and how often:

- Caffeine _____
- Tobacco/Cigarette _____
- Street Drugs _____
- Alcohol _____

Mark (x) if your work exposes you to:

- Stress _____
- Heavy Lifting _____
- Hazardous Substances _____
- Other _____

Your Occupation _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor, ever change in health.

Signature of Patient, Parent or Guardian

Relationship

Date

BARE FOOT CARE SPECIALIST, LLC

Podiatric Medicine & Surgery

Dr. Jeannette Velazquez

3485 Atlanta Highway

Flowery Branch, GA. 30542

PHONE NUMBER: 770-531-9222

FAX NUMBER: 770-531-9020

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Information (Please Print):

Name: _____ Date: _____

SSN: _____ - _____ - _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Please release my medical information to:

Bare Foot Care Specialist, Dr. Jeannette Velazquez

By signing this form I am authorizing a release of my medical records to the office mentioned above.

Signature

Date

**SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT,
AND TREATMENT CONSENT.**

Health and accident insurance policies are a contractual arrangement between an insurance carrier and the insured. It is the responsibility of the insured to verify eligibility for health care benefits. Possession of a medical insurance member ID card is **NOT** a guarantee of coverage. As a courtesy to you, we will gladly submit your medical bills to your insurance carrier.

1. **Primary Insurance:** I request that payment of authorized benefits be made on my behalf to **Bare Foot Care Specialist** for services furnished to me by **Bare Foot Care Specialist**. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. **Bare Foot Care Specialist** accepts the charge determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance, co-pays, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the carrier and are due at the time of service. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to **Bare Foot Care Specialist**. **As a courtesy, Bare Foot Care Specialist will file your insurance for you, however, by signing below you are stating that you understand that you as the patient are ultimately responsible for payment for services rendered.**
2. **Secondary Insurance:** I request that payment of authorized secondary insurance benefits be made on my behalf to **Bare Foot Care Specialist** if possible or otherwise to me, at which time I would forward all payments to **Bare Foot Care Specialist**.
3. **Release of Information:** **Bare Foot Care Specialist** may disclose all or any part of my medical record and/or financial ledger to any person or corporation (1) which is or may be liable or under contract with **Bare Foot Care Specialist** for reimbursement for services rendered and (2) any health care provider for continued patient care. **Bare Foot Care Specialist** may also disclose, on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statutes, or regulation.
4. **Non-Covered Services:** I understand that **Bare Foot Care Specialist** contracts with health insurance plans. Accordingly, the undersigned accepts full financial responsibility for all items and services which are determined by the health care insurance plan as non-covered services.
5. **Financial Agreement:** I agree that in return for the services provided to me by **Bare Foot Care Specialist** I will pay my account at the time service is rendered or will make financial arrangements satisfactory to **Bare Foot Care Specialist** for payment. **If my account is sent to collections, I agree to pay an additional 35% for collection fees.** I understand and agree that if my account is delinquent, I may be charged a service fee. It is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill. Furthermore, by signing below I acknowledge that I have been made aware that there is a \$25.00 fee for all returned checks and a \$35.00 fee for any missed appointments where proper notice is not given. **The parent/legal guardian bringing the child to our facility will be responsible for required co-payments, deductibles, etc., at the time of service.**
6. **Privacy Plan:** I agree that I have been given the opportunity to read and receive a copy of **Bare Foot Care Specialist's Notice of Privacy Practices**.
7. **Notice:** Anyone under the age of 18 will not be seen without a parent or guardian present unless you are an emancipated minor.
8. **Treatment Consent:** By signing below I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me, as the doctor deems necessary in the diagnosis and/or treatment of my feet and/or ankles.
9. **Additional Disclosure Authority:** Please indicate any additional parties we are allowed to speak with regarding your account (please circle):
 - Spouse? Name _____ YES NO Immediate Family? YES NO
 - Other? Name _____ YES NO
 - Can we leave a message regarding your health information on your answering machine? YES NO

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signature of Patient, Guardian or Representative

Date

Please Print Name

Relationship to Patient

Birth Date