

Welcome To Our Office!

THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH
SO PLEASE FILL THIS FORM OUT COMPLETELY

NAME OF PATIENT _____

SOCIAL SECURITY # _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SEX: M F AGE: _____ BIRTHDATE _____

MARITAL STATUS: S M D W

HOME PHONE _____ CELL _____

E-MAIL ADDRESS _____

EMPLOYER _____

OCCUPATION _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

OFFICE PHONE _____

PERSON RESPONSIBLE FOR ACCOUNT _____

STREET _____

CITY _____ STATE _____ ZIP _____

EMPLOYER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____

RELATIONSHIP TO PATIENT _____

BIRTHDATE _____

WHOM MAY WE THANK FOR REFERRING YOU TO US?

EMERGENCY CONTACT _____

RELATIONSHIP _____ PHONE _____

MEDICAL HISTORY

Have you had any serious illnesses? If yes, please explain:

Circle if you have (or had) a problem with any of the following:

Diabetes	Lungs	Asthma	Rheumatic Fever	Heart	Liver
Stroke	Kidneys	Thyroid	Stomach Ulcer	Phlebitis	Arthritis
Cancer	T.B.	Murmur	Hypertension	Bladder	AIDS/HIV
Skin	Anemia	Gout	Psychological	Epilepsy	Circulation
ADHD	RA	Psoriasis	Depression	Crohns/IBS	Fibromyalgia

For women: Are you pregnant or breast feeding? Yes No

ALLERGIES

Are you allergic or sensitive to any of the following (Please circle)? Please explain the reaction you get to the offending substance.

() Please check this box if you have NO KNOWN DRUG ALLERGIES

Penicillin	Morphine	Tape	Sulfa	Novocaine	Latex
Aspirin	Codeine	Iodine	Neosporin	Betadine	“-mycins”

Others (please list): _____

SURGERIES– Please list all surgeries/procedures that you have had. Please include when, where, and what surgical procedures. () Please check this box if you have never had surgery

Have you ever had a reaction or complication from anesthesia or surgery? If so please explain.

() Please check this box if you have NOT had complications from anesthesia or surgery

TRAUMATIC HISTORY – Have you ever had any SERIOUS injuries, accidents, or broken bones? If so, please list when, your treatment, and outcome.

HOSPITALIZATIONS – Have you ever been hospitalized for any reason? If so, please list when, where and for what reason. () Please check this box if you have never been hospitalized

FAMILY HISTORY – Please circle if any of your family members have (or had) any of the following:

Diabetes	Cancer	Heart Disease	Hypertension	Foot Problems
RA	Psoriasis	Gout	Arthritis	Charcot Marie Tooth

SOCIAL HISTORY

Your occupation: _____

Marital Status: _____ # of Children: _____

Do you smoke? Yes No # of packs per day: _____ # of years: _____

Previously Smoked? Yes No # of packs per day: _____ # of years: _____ Year Quit _____

Do you use smokeless tobacco or chewing tobacco? Yes No frequency/qty _____

Do you drink alcohol? Yes No

How would you describe your drinking? Circle those that apply:

Social	Light	Moderate	Heavy	Binge	Rarely	Never
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Do you use recreational/illicit drugs? Yes No Type: _____

Are you involved in a sport or exercise program? Yes No Please explain below:

We are dedicated to providing the best possible care and service to you. An essential element of your care and treatment is understanding your financial responsibilities. If you have any questions about the policies, please discuss them with our office manager and/or front office staff.

Health Insurance

We are contracted with most insurance plans to accept assignment of benefits. Our office will file your visit with the insurance company and will only collect your co-pay, deductible, and/or coinsurance when it applies. Please note: Our contract with your insurance carrier requires us to collect your co-pay at each visit.

If you have insurance coverage with a plan that we do not have a prior agreement with, the charge for your care and treatment are due at the time of service. In the event your health plan determines a service to be "non-covered", you will be responsible for the complete charge. Payment is due upon receipt of statement from this office.

Referrals

It is your responsibility to obtain a valid referral from your primary care physician when required by your insurance company.

Disability, Insurance Forms, Medical Records, and Copies of X-rays

There is a \$25.00 per form charge to fill out disability and insurance forms. Please mail or leave them at the front desk along with your payment. Forms will not be completed until payment is received. Please allow at least 3-5 working days for processing. We will call you once we have completed your request. There is a \$25.00 fee for copying x-rays and \$10.00 fee for medical records.

Medication Refills

Refills for medication prescribed by your doctor should be obtained by calling your pharmacy to request the refill. Please do not call the office, as this will only result in additional phone calls for you. Refills are not approved after normal business hours, weekends, or holidays, so please call in your refill request in time for the pharmacy to contact our office.

Cancellation Policy

Our office will make every attempt to confirm your scheduled appointment, but it is ultimately your responsibility to cancel or reschedule when necessary. Our office reserves the right to charge a \$25.00 fee for failure to inform our office of appointment cancellation.

I have read and understand the office policies, and I agree to be bound by it's terms. I also understand and agree that such terms may be amended from time to time by the practice.	
_____	_____
Signature	Date

Printed Name	

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE SERVICES THAT I RECEIVE.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

I UNDERSTAND THAT THERE WILL BE A \$30.00 NSF FEE FOR ANY RETURNED CHECKS.

SIGNATURE _____ DATE _____

FOR PATIENTS WITH INSURANCE COVERAGE, PLEASE READ AND SIGN:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFO. AND REQUEST THAT BENEFITS BE PAID DIRECTLY TO DR. MILLERS OFFICE FOR SERVICES RENDERED. I UNDERSTAND THAT DR. MILLER IS FILING MY CLAIM AS A COURTESY AND THAT THIS DOES NOT RELIEVE ME OF FINANCIAL RESPONSIBILITY OF NON-COVERED SERVICES OF SUPPLIES.

SIGNATURE _____ DATE _____

**ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I ACKNOWLEDGE THAT THE NOTICE PRIVACY PRACTICES WAS AVAILABLE AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I CHOOSE) AND UNDERSTAND THE NOTICE.

PATIENT NAME (PLEASE PRINT)

DATE

PARENT OR AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

SIGNATURE

Please read and sign this form. This form will help us receive insurance payment for your visit/services:

I assign the right to payment for all medical benefits directly to Jason C. Miller, DPM, PA in consideration for medical services and supplies provided to me pursuant to my health insurance plan.

In the event that my health insurance plan refuses to pay for medically reasonable and necessary services provided, I also assign all my ERISA* rights to Jason C. Miller, DPM, PA for a full and fair review of any and all denied claims, including any penalties that may be assessed against the insurance company for claims-processing violations. This ERISA assignment is in consideration for the unpaid services provided, in consideration for my insurance plan's reduced fee schedule, and in consideration for the continued willingness of Jason C. Miller, DPM, PA to see patients, including me, on an insurance assignment basis. I understand that if my treating doctor prevails in any payment dispute, I may be liable for any applicable co-payment for contested services.

I consent to release medical information to Jason C. Miller, DPM, PA. I consent to Jason C. Miller, DPM, PA releasing medical information to other health care providers for the purpose of treatment when necessary for my care. I consent to Jason C. Miller, DPM, PA sending all necessary medical information to my insurance plan.

*ERISA is an acronym for the Employee Retirement Income Security Act, which includes federal laws requiring insurance companies to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations. The failure to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations may result in fines charged to the insurance company in amounts of up to \$110 a day for each infraction.

Patient's Printed Name: _____

Patient's Signature: _____

Date: _____