FOOTClinic sc
FOOT CLINIC OF SOUTH CAROLINA

First Name	Middle	Last Name
Patient's Address		ZipCode:
Primary Phone Number	Other phone #	Email Address:
Date of birth	Social Security Number	Today's Date
Name of Ins Card Holder if other:	SSN of Insurance Holder	DOB of Ins Holder
Emergency Contact Name: PhoneNumber:		Relation:
How did you hear about our practice:	Friend _____	Google
Yellow Pages- Book	Yellow Pages Internet	Doctor
Foot Clinic Website	Insurance Company	Other: _____
Were you referred to us by your primary doctor?		
Who is your primary doctor:		
Please list any allergies you have:		
Height Weight	Do you Smoke? YES NO How many?	Do you consume alcohol? (circle one) NO 2-3 week 4-6 week more than 6 /wk

HAVE YOU EVER BEEN TREATED FOR:

Diabetes	Heart Disease/Heart Attack	Stroke Hepatitis
High blood pressure	Arthritis	Rheum. Fever HIV /AIDS
Kidney Disease	Liver Disease	Cancer/Type _____

DO YOU EXPERIENCE:

Bleeding problems	Leg cramps	Numbness in feet
Arch Pain	Tingling in feet	Back Pain
Ingrown Toenails	Poor Circulation	Foot Infections/Wounds

LIST OTHER MEDICAL CONDITIONS:

PLEASE EXPLAIN REASON FOR YOUR VISIT:

What Pharmacy do you use: address:

PLEASE LIST ANY SERIOUS ILLNESSES AND OPERATIONS:

PLEASE LIST YOUR MEDICATIONS AND DOSAGE:

Have you been treated by a FOOT DOCTOR before? YES No Name:
Reason:

I acknowledge and agree that SCPPSG/Foot Clinic of SC may: (CHECK ALL THAT APPLY)

___ Leave a message regarding upcoming appointments.

___ Leave a message regarding lab results/imaging studies/medication refills on my answering machine.

___ Leave a message regarding billing questions on my home answering machine.

I acknowledge and agree that Foot Clinic of SC/South Carolina Podiatric Physicians and Surgeons Group, LLC may disclose my protected health information and medical record information to the following individuals who are either, my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

_____

Print name, relationship, and phone number

_____

Print name, relationship, and phone number

I have read and understand the information on this consent. I may receive a copy of this consent if I so choose and I am the patient or the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms.

_____	_____	_____
Please Print Name	Patient's Signature or Authorized Representative	Date

E-PRESCRIBING CONSENT FORM

E-Prescribing is defined by a Physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an E-Prescribing program. These include:

Formulary and benefit transactions - gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

I authorize Foot Clinic of SC, LLC to view my external prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff a Foot Clinic of SC, LLC, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Foot Clinic of SC, LLC medical record.

Understanding all of the above, I hereby provide informed consent to Foot Clinic of SC, LLC to enroll me in the E-Prescribing program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction. This consent will remain in force until revoked or changed.

_____	_____	_____
Please Print Name	Patient's Signature or Authorized Representative	Date

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Patient Financial Policy

Thank you for choosing our practice for your Podiatric needs. We are committed to providing you with the best possible medical care. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

- Payment for all services provided by our practice is due in full at the time services are rendered. Exclusion to this policy are those patients who are members of a managed care or Insurance plan with which our practice participates.
- If we participate with your insurance plan, co-payments and any unmet deductible amounts will be required at the time you register. We will verify your insurance benefits at the time of service.
- If our practice does not have a contractual agreement with your insurance plan, you are responsible for the full payment at the time services are rendered.
- All patients are responsible for any non-covered services and will be asked to sign an Advanced Beneficiary Notice (ABN) for any non-covered services or supplies prior to the service. You will be responsible for your deductible, co-pays, and any service deemed medically unnecessary and all non-covered services or supplies.
- This practice will not file any secondary insurance to Medicare unless it is an e-crossover from Medicare, or a plan in which we participate. In this case, Medicare patients will be responsible for their co-payments and/or deductibles.
- This practice accepts Cash, Personal checks, MasterCard, and Visa as payment for services.
- A $30 Return Check Fee will be assessed to your account for every check returned to this practice. No checks will be re-deposited.
- Some plans require prior authorization from your primary care provider in order for our physicians to see you and receive payment from your insurance plan. While we make every effort to obtain this prior to the date of service, if we do not have this authorization number, we may need to reschedule your appointment. The member is ultimately responsible for the authorization, not our office nor the Primary Care Provider.
- If you are scheduled to have a procedure/surgery performed, we will conduct a pre-operative benefits check with your primary insurance company to determine as accurately as possible what your patient responsible amount will be after insurance pays. Payment is expected prior to the procedure being performed.
- Refunds will be issued (when applicable) on a monthly basis. Refunds will be given in the form of a check.
- If you do not give us 24 hours notice of an appointment cancellation, you may be subject to a $25 cancellation fee.
- If you do not have insurance or for services not covered by insurance, the practice requires payment of 100% of the total charges unless payment arrangements have been made. Please speak with our Office Manager if you have any questions or if you need information regarding our practice's self pay policies.
- It is our policy to send to the patient three consecutive monthly statements with any balance owed to the practice by the patient. Once all attempts at collections are exhausted, the patient's account is then placed with an outside collection agency with management's approval. After that time, the patient agrees to pay the cost of collection including a reasonable attorney's fee, if this account should be placed in the hands of an attorney for collections.
- We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in making payment arrangements.
- If you have any questions regarding our financial policies, please feel free to speak with our Financial Counselor or Office Manager. We will make every effort available to you to clarify any misunderstanding you have regarding your account.

PLEASE READ THE ABOVE INFORMATION CAREFULLY BEFORE SIGNING. By signing below, I acknowledge that I have read, understand, and agree to the terms of this policy. I also request that payment of authorized benefits be made to South Carolina Podiatric Physicians & Surgeons Group, LLC. I authorize them to release medical information to my Insurance plan and its agents any information needed to determine these benefits or the benefits payable to related services. The undersigned certifies that they are either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept the terms.

Patient or Representative Signature:_____Date:_____

A. Notifier: Foot Clinic of South Carolina, LLC

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If your insurance company doesn't pay for **D.** below, you may have to pay. Your insurance company does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance company may not pay for the **D.** below.

D.	E. Reason Your Insurance Company May Not Pay:	F. Estimated Cost
Nail Trimming **Callous Trim** **Ulcer Debriment** **Nail Biopsy** **Injections** **Xrays** **Ingrown Toenails** **Nerve Biopsy** **Orthotics** **DME**	**Insurance company may not deem medically necessary**	**Up to $3000**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but your insurance company cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** listed above. You may ask to be paid now, but I also want my insurance company billed for an official decision on payment, which is sent to me on an explanation of benefits (EOB). I understand that if my insurance company doesn't pay, I am responsible for payment, but **I can appeal to my insurance company** by following the directions on the EOB**.** If my insurance company does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** listed above, but do not bill my insurance company. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance company is not billed**.

☐ **OPTION 3.** I don't want the **D.** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my insurance company would pay.**

H. Additional Information:

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	**J. Date:**