Graser Podiatry & Bunion Surgery Inst

NEW PATIENT REGISTRATION

FILL OUT COMPLETELY

___Male ____Female Marital Status: __M__ S__ W__ D

Name: _____ DOB: ____ /____ /_____ SSN# _____ /_____ / _____

Address:_____ City: _____ State: _____ Zip: _____

Mailing Address (if different from above): _____

Primary contact Ph: _____ Cell:_____ Other: _____

Employer/Occupation: _____ Ph: _____

Primary Care Dr: _____ LAST VISIT: _____

Emergency contact: _____ Relation: _____ Ph: _____

Email:_____ Pharmacy Info: _____

How did you hear about us: _____ PCP _____ WEB _____ WALK IN _____ FB _____OTHER

May we leave _____TEXT _____VOICE messages/Appt reminders _____ CELL Ph _____EMAIL _____HOME Ph

INSURANCE- BILLING ORDER

PRIMARY INS: _____ Member ID#: _____ Group #: _____

SECONARY INS: _____ Member ID#: _____ Group #: _____

IF YOU ARE UNSURE PLEASE CALL MEDICARE COORDINATION OF BENEFITS PH: (855) 798-2627

INSURED POLICY HOLDER (If other than Patient)

Name: _____ Relation:_____ DOB:_____ SSN: _____

Preferred Statement delivery method (Mailed, Emailed, Texted link) #1_____ #2_____

AUTHORIZATION TO RELEASE AND ASSIGNMENT OF BENEFIT

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS OR TO SEEK FURTHER TREATMENT. I ALSO ACKNOWLEDGE THAT I AM AWARE THAT A NOTICE OF PRIVACY PRACTICES IS AVAILABLE TO ME. UPON REQUEST AND THAT CHANGES TO MY NOTICE MAY OCCURE BUT I MAY ASK FOR A REVISED COPY OF THE NOTICE. I HEREBY AUTHORIZE GRASER/MEDINA PODIATRY & BUNION SURGERY INST TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED BY DR. ROBERT E. GRASER, OR BY HIS ORDER. I REQUEST THAT PAYMENTS FROM MY INSURANCE COMPANY BE PAID DIRECTLY TO: DR ROBERT E GRASER DPM, PA
DBA: GRASER PODIATRY & BUNION SURGERY INST / OR THE PARTY WHO ACCEPTS ASSIGNMENT-ASSOCIATES
I CERTIFY THAT THE INFORMATION I HAVE REPORTED REGARDING MY INSURANCE COVERAGE IS CORRECT. THIS AUTHORIZATION MAY BE REVOKED BY EITHER ME OR MY INSURANCE AT ANY TIME IN WRITING.

SIGNATURE **X** _____ DATE ____/____/_____

MEDICAL HISTORY

MEDICAL FOOTWARE: HEIGHT _____ WEIGHT _____ SHOE SIZE _____ SHOE WIDTH_____

Please describe your present foot problem: _____
_____
_____
_____

How long have you had this foot problem: _____
_____
_____
_____

Have you been treated in the past for this problem? ____ NO ____Yes *explain below*

WHAT TYPE: _____
WHEN: _____
WHERE: _____

___ Gout	___ Varicose Veins	___ Kidney Problems	___ Tuberculosis
___ Anemia	___ Tumors/Growth	___ Bleeding Diffuclty	___ Hypertension
___ Cancer	___ Healing Problems	___ Muscular Disorder	___ Cholesterol
___ Epilepsy	___ Swelling Feet	___ Shortness of breath	___ Hay Fever
___ Stroke	___ Stomach Ulcer	___ Rheumatic Fever	___ Heart Trouble
___ Arthritis	___ Liver Problems	___ Circulation Problems	

___ OTHER _____

Are you diabetic: ___ NO ___ YES If Yes, What Type: _____

Family history of Diabetes : ___ NO ___ YES Diagnosed with Neuropathy: ___ NO ___ YES

MEDICATION ALLERGIES: ___ NO ___ YES

___ Penicillin	___ Lidocaine	___ Sulfa Drugs	___ Adhesive Tapes
___ Codeine	___ Anesthetics	___ Iodine	___ Other Antibiotics
___ Foods	___ Other (Specify) _____		

***** REACTION***_____**

Are you currently taking PRESCRIPTION Medications: ___ NO ___ YES *please list below*

1- _____ 5- _____
2- _____ 6- _____
3- _____ 7- _____
4- _____ 8- _____

FINANCIAL AND APPOINTMENT POLICY

BILLING AND INSURANCE

Please be prepared to pay your copayment, coinsurance, and deductible prior to your appointment. We accept most health insurance; Please CALL your Health Insurance to verify network participation and for verification on referral or authorization requirements.

- All co-pays, deductibles, co-insurances, and previous balances are the financial responsibility of the patient and due at check in. If you are unsure of any, please contact your Health Insurance plan BEFORE your office visit.
- Failure to give a our office a 24-hour notice for reschedules or cancellations will be considered a No-Call/ No-Show and result in a $40.00 penalty fee and must be collected prior to your next appt.
- All balances due from the patient are payable immediately. If you are unable to make payment in full, please speak to the billing office to make financial arrangements.
- Insurance is filed as a courtesy to our patients. If you have insurance but cannot produce a valid card, you will be considered a "self-pay" patient and payment in full will be expected at each visit until a valid card is produced. No insurance will be filed on services over 30 days old.
- INSURANCE CARDS MUST BE VALID AT THE TIME OF APPOINTMENT. IT IS FULL PATIENT RESPONSIBILITY TO REPORT ALL CHANGES OF INSURANCE AND DEMOGRAPHICS TO US BEFORE ANY OFFICE VISIT/ SCHEDULING. FAILURE TO DO SO WILL RESULT IN CARE DELAY AND FULL FINANCIAL RESPONSIBILITY.
- ANY CLAIM DENIALS BY ANY TYPE OF INSURANCE DUE TO INCORRECT INFORMATION GIVEN BY THE PATIENT OR FAILURE TO UPDATE INFORMATION ON FILE WITH US WILL BE FULL PATIENT RESPONSABILITY. IF UNSURE OF WHO YOUR PRIMARY PAYOR IS, YOU NEED TO CALL MEDICARE'S COORDINATION OF BENEFITS PHONE: (855)798-2627

X _____

MEDICARE- We accept assignment on Medicare claims. Medicare patients will be expected to pay their deductible (if not met) or 20% co-payment on the service date. For Patients with traditional Medicare, It is important that you give us the correct DATE LAST SEEN of your Primary Care Provider for billing purposes. Medicare requires this information on our claims for reimbursement on the services rendered to you. WE ARE REQUIRED TO ASK THIS ON EVERY VISIT. Failure to provide us with the correct information may result in Patient financial responsibility.

X _____

HOSPICE- Patients on Hospice are required to notify the office prior to the scheduled Appointment. Failure to do so will result in full Patient financial responsibility

X _____

SELF-PAY/NO INSURANCE- We offer a discounted fee schedule for Patients who cannot provide satisfactory proof of insurance. If Self-Pay patients are on a Payment Plan (subject to approval) and fail to make a payment or arrangements before scheduled payment/office visit, then the Self-Pay Discount will be forfeited, and the patient will be obligated and required to pay the full charges. All patients are required to pay 100% of charges at the time of initial visit.

X _____

DOCTOR APPOINTMENTS

We understand there are times when appointments are missed due to emergencies. However, when you do not call to cancel an appointment, you are preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit due to a seemingly "full" appointment book. All cancellations and reschedules of follow-up appointments require a 24-hour notice. Please note that failure to notify our office **at least 24 hours in advance will be considered a NO-SHOW and charged a fourty dollar ($40) penalty fee**; this will not be covered by your insurance company. The Patient will be responsible for payment in full before next scheduled appointment. Repeated missed appointments will result in a "walk-in" status or dismissal from our practice and out to another Specialist/ Podiatrist.

X _____

LATE APPOINTMENTS

We understand that delays can happen however we must try to keep the other patients and doctors on time. Patients running late must call the office to verify that they can still be seen. If we can, there might be a waiting time. If we are unable and need to reschedule, this will be considered a No-Show, penalized with a fee and would then need to be re-scheduled.

X _____

APPT REMINDERS OR CONFIRMATIONS

As a "courtesy" to our Patients we try our best to personally call each and everyone to remind "OR" confirm Appt's. Unfortunately this is not always possible, therefore we rely on our Automated system to remind or confirm by calls/ texts. It is important to update the preferred method of contact including ANY changes to contact numbers, addresses or Insurances . Ultimately, it is the Patients responsibility to remember the date and time of their Appt. Due to our growing wait list we are required to confirm Appt's at least 24hrs of the scheduled Appt time. ***** ANY UNCONFIRMED APPT DUE TO WRONG INFORMATION ON FILE WILL BE REMOVED FROM OUR SCHEDULE 24HRS BEFORE THE SCHEDULED TIME OF THE APPT *****

X _____

SURGERY

Due to large block of times needed for surgery, last minute cancellations can cause problems and added expenses for the office. If surgery is not canceled at least 48 hours in advanced, you may be fined and you will be charged a two hundred-dollar ($200) fee; this is **will not** be covered by your insurance company **an**d the Patient will be responsible for full payment before next scheduled appointment.

X _____

MEDICAL RECORDS AND FORMS

We strongly adhere to HIPAA regulations to maintain the confidentiality of our patients' medical records. Patient consent is required before records can be released to any insurance company, law office or any other entity. Our office will charge a fee for Records, forms, and narrative letters due upon receipt. Please allow 3-7 business days for completion. Please fill out our Medical Release Form and fax to 830-253-0007.

BY SIGNING BELOW, I CONFIRM THAT I HAVE READ, UNDERSTOOD AND AGREED TO THE OFFICE POLICIES

SIGNATURE _____ **DATE** ____/____/_____