# REGISTRATION FORM

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Associated Podiatry Group of San Carlos

PATIENT'S NAME: _____ MALE FEMALE
FIRST MI. LAST (CIRCLE ONE)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

PERFERRED CONTACT NUMBER: ☐ HOME ☐ CELL ☐ WORK

SOCIAL SECURITY#: _____ BIRTHDATE: _____ AGE: _____ MARITAL STATUS: S M D W
(CIRCLE ONE)

BILLING ADDRESS (IF DIFFERENT THAN ABOVE) _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ OCCUPATION: _____

NAME OF YOUR PRIMARY CARE DOCTOR: _____ LAST VISIT: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

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## INSURANCE INFORMATION

( A COPY OF YOUR INSURANCE CARD IS ALSO REQUIRED)

PRIMARY INSURANCE: _____ GROUP #: _____

SUBCRIBER NAME: _____ SUBSCRIBER # _____

SUBSCRIBER'S RELATIONSHIP TO INSURED: ( )SELF ( )SPOUSE ( )CHILD ( )OTHER SUBSCRIBER DOB: _____

SECONDARY INSURANCE: _____ GROUP #: _____

SUBSCRIBER NAME: _____ SUBSCRIBER #: _____

SUBSCRIBER'S RELATIONSHIP TO INSURED: ( )SELF ( )SPOUSE ( )CHILD ( )OTHER SUBSCRIBER DOB: _____

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I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THESE CLAIMS AND I REQUEST PAYMENT OF INSURANCE BENEFITS TO: ASSOCIATED PODIATRY GROUP OF SAN CARLOS. I AGREE THAT UNPAID INSURANCE BALANCES ARE MY RESPONSIBILITY.

SIGNED: _____ DATE: _____

FOR OFFICE USE ONLY

PHOTO ID: _____ VERIFIED: _____ DATE: _____// UPDATED: _____ - _____ - _____

# Associated Podiatry Group of San Carlos

## Policy For Non-Covered Services and Supplies

Many insurance providers, including Medicare, do not provide coverage for all aspects of your recommended medical treatment(s) by our doctors.

We feel that it is important for you to know this in advance, as payment is generally required at the time of service for following items:

**Orthotics**: (shoe inserts), whether pre-made or custom functional orthotics.

**Medications**: Including but not limited to oral and topical medications, regardless of whether or not they require a prescription or are considered "over-the-counter."

**Medical Supplies**: i.e. bandages, pads and cushions, post-operative shoes, splints, walking casts, Coban, lamb's wool, insoles, etc.

**Medicare Patients Only**:

**Routine Foot Care**: According to Medicare, routine foot care is defined as: "the cutting and removal of corns and calluses; the trimming, cutting or debriding of nails (including mycotic - fungal); other hygienic and preventive self care such as cleaning and soaking the feet and use of skin creams to maintain skin tone for both ambulatory and bedfast patients; and any service performed in the absence of illness, injury or symptoms involving the foot." Routine foot care is conditionally covered by Medicare Part B only when the patient's condition is considered to be "at risk" and involves specific systemic (i.e. diabetes) or neurological conditions and the patient is under the active care of a Primary Care Doctor who documents the condition. Mycotic nail infections are covered under certain circumstances only.

**Many commercial insurance plans (i.e. HMO's and PPO's) are no longer allowing treatment for routine treatments/conditions.**

## Financial Responsibility Policy

It is important that you are familiar with the coverage and benefits provided to you via your health insurance plan, as all plans are different. We encourage all of our patients to review the Summary of Benefits provided to you by your health insurer and be familiar with eligible medical expenses along with limitations or exclusions in your policy. Deductibles, coinsurance amounts, co-pays and limitations relating to existing conditions may apply and are the financial responsibility of the patient or guarantor.

The fee for a check returned by our bank is $25.00.

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I understand that my health insurance carrier(s) may not cover all of the medical services and/or supplies provided by my Podiatrist. I agree to accept full financial responsibility for payment of denied or non-covered services and/or supplies.

_____ _____

Patient Signature Date