

HARRISBURG FOOT AND ANKLE CENTER, INC.

ALLAN B. GROSSMAN, D.P.M., F.A.C.F.A.S.

BRIAN D. CRISPELL, D.P.M.

AMBER L. TREASTER, D.P.M.

2200 DOVER ROAD

HARRISBURG, PA 17112

717-651-0000

PATIENT'S LAST NAME		FIRST NAME	MIDDLE INITIAL	HEIGHT	WEIGHT	SHOE SIZE	BIRTHDATE	AGE
RESIDENCE ADDRESS				CITY	STATE	ZIP	HOME PHONE NUMBER	
SEX M <input type="checkbox"/> F <input type="checkbox"/>	MARITAL STATUS SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		SOCIAL SECURITY NUMBER			DRIVER'S LICENSE NUMBER		
NAME OF POLICY HOLDER		SOCIAL SECURITY #		BIRTH DATE		RELATIONSHIP TO PATIENT		
POLICY HOLDER ADDRESS (if different from patient)					CITY	STATE	ZIP	
POLICYHOLDER/EMPLOYER		EMPLOYER ADDRESS				EMPLOYER PHONE NUMBER		
STUDENT Full Time <input type="checkbox"/> Part Time <input type="checkbox"/>		SCHOOL NAME AND ADDRESS						
SPOUSE EMPLOYER		EMPLOYER ADDRESS				EMPLOYER PHONE NUMBER		
EMERGENCY CONTACT PERSON		ADDRESS		PHONE NUMBER OF CONTACT PERSON			RELATIONSHIP TO PATIENT	
REASON PATIENT IS BEING SEEN		WHEN DID THIS PROBLEM BEGIN?		JOB RELATED YES <input type="checkbox"/> NO <input type="checkbox"/>			ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>	
HAVE YOU HAD PREVIOUS TREATMENT BY A PODIATRIST FOR THIS CONDITION? YES <input type="checkbox"/> NO <input type="checkbox"/>				WHEN?		DOCTOR'S NAME		
HOW DID YOU HEAR OF US?		PERSON OR PHYSICIAN WHO REFERRED YOU		NAME OF FAMILY PHYSICIAN			FAMILY PHYSICIAN TELEPHONE NUMBER	

PLEASE BE ADVISED THAT FOR ANY PORTION OF YOUR CHARGES THAT YOUR INSURANCE COMPANY DOES NOT COVER AND IS YOUR RESPONSIBILITY TO PAY, YOU WILL BE ALLOTTED 30 DAYS TO MAKE PAYMENT IN FULL. AFTER 30 DAYS, A \$5.00 PER MONTH SERVICE CHARGE/DELINQUENCY FEE WILL BE ASSESSED. AFTER 90 DAYS, IF PAYMENT HAS STILL NOT BEEN MADE, YOUR ACCOUNT WILL BE FORWARDED TO A COLLECTION AGENCY AND ALL ADDITIONAL FEES INVOLVED WITH THE COLLECTION PROCESS WILL BE ADDED TO YOUR ACCOUNT RESPONSIBILITY. I UNDERSTAND THAT I WILL BE RESPONSIBLE TO INFORM YOU IF I SEE ANOTHER SPECIALIST WITHIN THE TIME ALLOTTED BY MY INSURANCE COMPANY. I FURTHER UNDERSTAND THAT IF MY INSURANCE COVERAGE CHANGES, I WILL NOTIFY YOU WITH THE CORRECT INFORMATION. I HAVE READ AND UNDERSTAND THE ABOVE POLICY AND AGREE TO ADHERE TO ITS GUIDELINES.

PATIENT SIGNATURE

DATE

HARRISBURG FOOT AND ANKLE CENTER PATIENT REGISTRATION

1. ASSIGNMENT AND RELEASE:

I, THE UNDERSIGNED, HAVE INSURANCE AND ASSIGN THE PAYMENT DIRECTLY TO THE HARRISBURG FOOT AND ANKLE CENTER, INC. FOR ALL INSURANCE/MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY THE INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS.

PATIENT SIGNATURE: _____ DATE: _____

2. MEDICARE AUTHORIZATION:

I REQUEST THAT PAYMENTS OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE HARRISBURG FOOT AND ANKLE CENTER, INC. FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN, 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 PAYABLE FOR RELATED SERVICES. I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF OTHER HEALTH INSURANCE IS INDICATED ON ANY CLAIMS, MY SIGNATURE AUTHORIZES RELEASE OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. CERTAIN SERVICES MAY NOT BE COVERED OR FULLY REIMBURSED BY MEDICARE. I AUTHORIZE THE DOCTOR TO PROCEED WITH THE SERVICES WHETHER OR NOT COVERED BY MEDICARE. IF MEDICARE DENIES PAYMENT, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT. IN MEDICARE ASSIGNED AND COVERED CASES, THE PHYSICIAN AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE. THE PATIENT IN THAT CASE IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE, AND NON COVERED SERVICES.

SIGNATURE: _____ DATE: _____

NAME OF BENEFICIARY: _____ POLICY #: _____

3. WORKERS COMPENSATION:

I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT IN THE EVENT THAT MY CLAIM FOR WORKERS COMPENSATION BENEFITS IS DENIED.

PATIENT SIGNATURE: _____ DATE: _____

4. PEDIATRIC ASSIGNMENT AND RELEASE:

I CERTIFY THAT MY MINOR/CHILD IS COVERED BY THE INSURANCE ON THE FRONT PAGE AND ASSIGN IT DIRECTLY TO THE HARRISBURG FOOT AND ANKLE CENTER, INC. ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL OF MY INSURANCE SUBMISSIONS.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

5. MEDICAL ASSISTANCE:

MY SIGNATURE CERTIFIES THAT I RECEIVED THE SERVICES SUBMITTED. I UNDERSTAND THAT PAYMENT FOR THIS SERVICE OR ITEM WILL BE FROM FEDERAL OR STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF MATERIAL MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS.

PATIENT SIGNATURE: _____ DATE: _____