Alpine Podiatry

Registration Form

Patient Information

Name:_____ SS#:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip:_____

Sex: __F __M Birthdate:_____ Marital Status: __M __S __W __D

Patient Employer:_____ Occupation:_____

Employer Address:_____ Emp. Phone:_____

Whom may we thank for referring you?_____

Emergency Contact:_____ Phone:_____

Primary Insurance

Person responsible for account:_____Birthdate:_____
Relationship to patient:_____ SS#:_____
Address(if different than patient):_____
City:_____ State:_____ Zip:_____
Person responsible Employed by:_____
Business Address:_____ Phone:_____
Insurance Company:_____
ID#_____ Group#_____

Additional Insurance

Person responsible for account:_____
Relationship to patient:_____ SS#:_____
Address(if different than patient):_____
City:_____ State:_____ Zip:_____
Person responsible Employed by:_____
Business Address:_____ Phone:_____
Insurance Company:_____
ID#_____ Group#_____

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Medical History

Date:_____
Patient Name:_____Date of Birth:_____
Primary Physician:_____ Phone:_____
Date Last Seen:_____
What Type of Problems are you having with your feet?_____
_____

Past Medical History:(Please check any of the following conditions you currently have or have had in the past.)

__Diabetes	__Heart Attack	__Burning in feet	__Chemical Dependency
__Cancer	__Blood clots	__Numbness in feet	__Bleeding Disorders
__Stroke	__Liver Disease	__Lung Disease	__Rheumatoid Arthritis
__Gout	__Stomach Ulcer	__Sickle Cell Anemia	__Degenerative Arthritis
__HIV+	__Heartburn/Reflux	__Thyroid Disease	__Seizures
__Anemia	__High Blood Pressure	__Glaucoma	__High Cholesterol
__Alcoholism	__Kidney Disease	__Cataracts	__ Psychiatric Disorders
__Asthma	__Heart Disease	__Depression	
__Hepatitis	__Heart Murmur	__Pacemaker	

Are you pregnant?_____

Are you currently being seen by a pain management center? _____

Please list any other conditions that we should know about:_____

Medications:(List Medications that you are currently taking.)
_____
_____
_____

Family History: Has any of your immediate family had any of the following:
Cancer_____ Heart Disease_____ Stroke_____
Diabetes_____ Arthritis_____
Melanoma_____ High Blood Pressure_____

Allergies:(Please list medicines you have had an allergic reaction to in the past)
_____
_____
Are you allergic to: __Tape __Iodine __IVP Dye __Shellfish __Latex __Other_____

Social History:
Do you use Tobacco?_____ How Much per day?_____ How many Years?_____
Do you Drink Alcohol?_____ How many drinks per week?_____
Do you use any recreational drugs?/what kind?_____

Past Surgical History:

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Assignment: Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Alpine Podiatry Center, PA for any services furnished me by the listed provider/supplier. 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 or the benefits payable for related services.

I request payment of authorized Medicare benefits be made to this provider and also authorize any holder of medical information about me to release to the below named Medicare insurer any information needed to determine benefits payable for services from this provider.

I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature authorizes releasing of the information to the insurer or agency, electronically, or by mail. In Medicare assigned cases, this office agrees to accept the "charge determination" of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the "charge determination" of the Medicare carrier.

Patient Name (please print) Date

X _____ _____

Patient Signature

X _____

Patient Medicare Number

_____

Alpine Podiatry

Patient Financial Policy

We are dedicated to providing the best possible care and service to you and regard your complete understanding our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

- We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service

- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

- You must inform the office of all-insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

- There are certain elective surgical procedures that we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Printed Name: _____ Date: _____

Signature: _____

Alpine Podiatry

Christopher H. Crabtree, DPM Catherine A. Paukovitz, DPM

Notice of Privacy Practices

Alpine Podiatry Center complies with HIPAA regulations to keep your medical information private and secure. We require you to sign that you have been given this guarantee.
If you would like a detailed copy of our HIPAAcompliance policy, please ask a staff member and we will be glad to give you a personal copy.

I acknowledge that I have been provided the opportunity to review the privacy policy of this practice:

Name: _____

Signature: _____

Date: _____

If you think that we may have violated your privacy right, contact Dr. Christopher Crabtree at:
Alpine Podiatry Center
P.O. Box 337 Fort Mill, SC 29708
803-396-8670

You may also submit a written complaint to the U.S. Department of Health and Human Services at the following address:
200 Independence Avenue, S.W.
Washington, D.C. 20201
We will not retaliate in any way if you chose to file a complaint.

430 S. Herlong Ave. #105
Rock Hill, SC 29732
Phone: 803-327-2217
Fax: 803-396-8657

105 Ben Casey Dr. #133
Fort Mill, SC 29708
Phone: 803-396-8670
Fax: 803-327-2272