Burkman Podiatry

DEMOGRAPHICS & INSURANCE

Patient Information

Name: _____
(First) (MI) (Last)

SS#: _____ DOB: _____ Sex: □ Male □Female

Email:_____ Street Address:_____

City, State, Zip Code:_____

Preferred Phone Number: _____Other Phone Numbers:_____

Appointment confirmation calls will always be made to the preferred phone number and a message with your appointment details will be left.

□ I consent to receiving automated phone call and text reminders about my appointments.

Primary Care Physician: _____ Date of Last Visit: _____

Preferred Pharmacy: _____ Location: _____

Emergency Contact: _____
(Name) (Phone)

Ethnicity: □Hispanic/Latino □not Hispanic/Latino AND Primary Language: □ English □Spanish □Other

Race: □American Indian/Alaska Native □Asian □Black/African American □Hawaiian/ Pacific Islander □White

Marital Status: □ S □ M □ D □W

Financially Responsible Party Information (if different than patient)

Name: _____ Relationship:_____
(First) (MI) (Last)

SS#:_____ DOB:_____ Phone Number: _____

Address: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Insurance Subscriber Information (if different than patient)

Name: _____SS#:_____ DOB:_____ Relationship:_____
(First) (MI) (Last)

Authorization to Disclose Health Information

**By selecting appointment information this individual has the right to confirm, change, and cancel appointments, as well as know all past appointment history. **

Name: _____ Relationship: _____
May disclose (select all that apply): □ Billing Information □Medical Information □Appointment Information

Name: _____ Relationship: _____
May disclose (select all that apply): □ Billing Information □Medical Information □Appointment Information

Name: _____ Relationship: _____
May disclose (select all that apply): □ Billing Information □Medical Information □Appointment Information

Burkman Podiatry

MEDICAL HISTORY

Reason for Visit: _____

How did you hear about the office? _____ Shoe Size: _____ Height: _____ Weight: _____

PQRS (Physician Quality Reporting System) Questions:

Have you experienced 2 falls OR any falls with injury in the last year: ▫Yes ▫No

Have you received an influenza vaccination this year? ▫Yes ▫No

Have you received a pneumonia vaccination this year? ▫Yes ▫No

Do you drink alcoholic beverages: ▫Yes ▫No If so, how many drinks per day? _____

Do you smoke: ▫No ▫<5 cigarettes per day ▫½ pack per day ▫1 pack per day ▫>1 pack per day

Allergies: (please check those that apply or provide a list to copy) ▫**NONE**

▫Penicillin ▫Iodine ▫Aspirin ▫Adhesive Tape ▫Sulfa
▫Codeine ▫Seafood/Shellfish ▫Local Anesthetics ▫Other_____

Reaction: _____

Current Medications: Prescription and Non-Prescription (Or provide a list to copy)

_____

_____

Past Surgical History:

_____

_____

Past Medical History: (Please check all that apply)

▫Anemia	▫Bleeding Disorders	▫Hepatitis	▫PVD	▫Stroke
▫Arthritis	▫Diabetes TYPE 1 OR 2	▫High Blood Pressure	▫Neuropathy	▫Cancer
▫Asthma	▫Gout	▫Kidney Problems	▫Numbness in Feet	▫Other
▫Renal Disease	▫Heart Disease	▫Liver Disease	▫Poor Circulation	▫NONE

Mother's Medical History: (Please check all that apply)

▫Anemia	▫Bleeding Disorders	▫Hepatitis	▫Lung Problems	▫Stroke
▫Arthritis	▫Diabetes	▫High Blood Pressure	▫Neck Pain	▫Cancer
▫Asthma	▫Gout	▫Kidney Problems	▫Numbness in Feet	▫Other
▫Back Pain	▫Heart Disease	▫Liver Disease	▫Poor Circulation	▫NONE

Father's Medical History: (Please check all that apply)

▫Anemia	▫Bleeding Disorders	▫Hepatitis	▫Lung Problems	▫Stroke
▫Arthritis	▫Diabetes	▫High Blood Pressure	▫Neck Pain	▫Cancer
▫Asthma	▫Gout	▫Kidney Problems	▫Numbness in Feet	▫Other
▫Back Pain	▫Heart Disease	▫Liver Disease	▫Poor Circulation	▫NONE

I hereby give my permission to the doctor(s) at Burkman Podiatry to perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in diagnosis and/or treatment of my feet and/or ankles.

PATIENT SIGNATURE: _____ **DATE:** _____

Burkman Podiatry

FINANCIAL POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high-quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. We accept Medicare benefit amounts. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for full payment of these services at the time of service.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates that when you visit a specialist such as ours, you may need to have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: ***All co-payments, co-insurance, or deductible amounts must be paid AT THE TIME OF SERVICE.*** This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion of insurance benefits at each visit. As a courtesy, our office does verify benefits with your insurance carrier; however, the insurance agreement is a contract between you and your insurance carrier. It is recommended that you verify your benefits with your carrier as well.

PHYSICIAN PHONE CALLS: Phone calls with our physician(s) are a billable service, may be billed to your insurance company/companies, and are subject to your insurance benefits. You are responsible for your portion of insurance benefits for physician phone calls.

NON-CUSTOM DURABLE MEDICAL EQUIPMENT RETURNS: If a patient is unsatisfied with any non-custom Durable Medical Equipment item, it must be returned within 30 days per Medicare guidelines. Returns after 30 days will not be permitted. The item will only be accepted as a return if it is in returnable condition. Any custom durable medical equipment item may not be returned for any reason.

COPY FEE: We will provide copies of patient records at the patient's request. Copies of records may be subject to a $0.05 per single page copy fee. You will bear complete financial responsibility for any fee(s) incurred.

CANCELLED/MISSED APPOINTMENT FEE: If you cannot keep your appointment time, please call our office at least 24 hours prior to your scheduled appointment time. There is always an answering machine available to take a message in case you call after hours. There may be a **$25 fee** for any appointment cancelled or rescheduled within 24 hours of the scheduled time. Additionally, there may be a **$25 fee** if you miss a scheduled appointment. If you miss 3 or more appointments, you may be required to pay a $50 deposit to hold any future appointment time slots. If you arrive late for an appointment, we may need to reschedule your appointment. You will bear complete financial responsibility for any fee(s) incurred. Repeated missed or late appointments may result in dismissal from our practice.

COLLECTIONS FEE: If you have health insurance, your claim will be submitted. If after your claim has been processed there is a balance due, you will be sent a bill. Our bills are due upon receipt. If payment is not received by the date indicated on the bottom of the billing statement (30 days following the statement date), the balance due will be charged to the bank card stored on file. If payment is received BEFORE the date indicated, your card will never be charged.

Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA/MasterCard/Discover. An additional $25.00 will be added to your statement if the check is returned from your bank. We do not accept starter checks. In the event that your insurance company sends payment to you, the patient, it should be forwarded to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* to Burkman Podiatry for medical services provided. I agree to pay Burkman Podiatry any balance unpaid by my insurance carrier for myself or the below named person.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to its terms.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Burkman Podiatry** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees **AT THE TIME OF SERVICE.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize Release of Medical Information to my insurance carrier or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms:

PRINT Patient Name: _____ **Signature:** _____ **If**

patient is under 18, please complete the following for the *FINANCIALLY RESPONSIBLE PARTY*:

PRINT Name: _____ **Signature:** _____

Relationship to Patient: _____ **Date:** _____

Checklist: Review of Systems

Mark any of the following that you are currently experiencing:

General-

- o Weight loss or gain
- o Fatigue
- o Fever or chills
- o Weakness
- o Trouble sleeping

Head-

- o Headache
- o Head injury

Respiratory-

- o Cough (dry/wet/productive)
- o Sputum
- o Coughing up blood
- o shortness of breath
- o painful breathing

Cardiovascular-

- o Chest pain/discomfort
- o Tightness
- o Palpitations
- o Shortness of breath w/ activity
- o Difficulty breathing while laying down
- o Swelling
- o Sudden awakening from sleep

Gastrointestinal-

- o Swallowing difficulties
- o Heartburn
- o Change in appetite
- o Nausea
- o Change in bowel habits
- o Rectal bleeding
- o Constipation
- o Diarrhea
- o Yellow eyes/skin

Skin-

- o Rashes
- o Lumps
- o Itching
- o Dryness
- o Color changes
- o Hair/nail changes

Vascular-

- o Calf pain w/walking
- o Leg cramping

Musculoskeletal-

- o Muscle/joint pain
- o Stiffness
- o Back pain
- o Joint redness
- o Joint swelling
- o Trauma

Neurologic-

- o Dizziness
- o Fainting
- o Seizures
- o Weakness
- o Numbness
- o Tingling
- o Tremor

Hematologic-

- o Ease of bruising
- o Ease of bleeding

Endocrine-

- o Heat/cold intolerance
- o Sweating
- o Frequent urination
- o Thirst
- o Change in appetite

Psychiatric-

- o Nervousness
- o Depression
- o Memory loss
- o Stress

- o NONE OF THESE APPLY TO ME

Patient Signature Date

BILLING AGREEMENT

Date: _____

Patient Name: _____ **DOB:** _____

PLEASE READ:

Due to the recent increase in high deductible plans, it is now the policy of Burkman Podiatry to require either a Credit/Debit Card or HSA/ Flexible Spending Card to be kept on file for ALL patients. All visits will first be charged to your designated insurance carrier/provider for services rendered by Burkman Podiatry.

If your claim comes back with a patient responsibility balance such as co-pays/coinsurance/deductibles you will receive a statement. You will have 30 days from the statement date to pay your balance in full. Any remaining balances will then be charged to the card kept on file. All cards will be stored electronically in our Payment Card Industry (PCI) Complaint & Cyber Security Insured system to protect and alleviate any worries you may have of a cyber-attack. The card on file information visible to Burkman Podiatry is limited to the last 4 digits of your card number and expiration date. Your card on file can only be used to pay account balances incurred at Burkman Podiatry, through our secured payment terminal powered by Square Terminal. If you pay your bill by the due date, your card will never be charged. If you would like to use the card on file to pay your bill, do nothing and the card will be charged on the date posted on your statement.

It is YOUR responsibility to notify us of any change to your insurance so that we can determine if there is any change in your benefits.

You, the Patient/Parent/Guardian/Co-Signer, by signing this agreement, agree to allow Burkman Podiatry to utilize your Credit/Debit Card or HSA/Flexible Spending Card to pay all fees and costs due to Burkman Podiatry at any time if money is owed after your primary insurance carrier has been billed or from amounts excluded from your insurance (i.e. Cancellation/No Show fees). You further agree to allow Burkman Podiatry to scan the Credit/Debit Card or HSA/Flexible Spending Card kept on file in our secured payment terminal powered by Intuit, Inc.

All account numbers and charges made by Burkman Podiatry are generally confidential and are protected from disclosure except as provided by law.

Refusal to provide your credit card information to be stored is in violation of our billing agreement and therefore we reserve the right to refuse service to you. Your signature indicates your understanding and compliance with this policy.

_____ _____

Patient Name (Print) **Patient Signature**

_____ _____

Parent/ Guardian Name (Print) **Parent/ Guardian Signature**

Name on Card: _____ Billing Zip Code:_____

Card#_____ CVV#_____ Card Exp Date:_____

BILLING AGREEMENT
FAQ's

IT IS THE POLICY OF BURKMAN PODIATRY TO REQUIRE EITHER A CREDIT/DEBIT CARD OR HSA/FLEXIBLE SPENDING CARD TO BE KEPT ON FILE FOR ALL PATIENTS.

WHY DO YOU NEED TO STORE MY CREDIT CARD?
In order for our practice to run properly and provide excellent care, we require payment for services rendered. With the changes in healthcare plans and increase in deductibles, balances (either all or a portion) are often the responsibility of the patient after their claim has been processed.

WHAT IS THE NAME OF THE COMPANY YOU USE TO STORE MY CARD INFORMATION?
The product/service we use for storing your credit card and to process all payments is the Square Terminal (Square, Inc.). Square keeps payment information safe by encrypting all information (whether a payment or storing information) as soon as it's received. Square monitors all transactions to detect suspicious behavior. Square card processing applications adhere to Payment Card Industry (PCI) Data Security Standard (Level 1) and is Compliant & Cyber Security insured.

WILL SQUARE SHARE OR SELL MY INFORMATION STORED?
Square will not rent or sell your personal information to others. The only information shared is what is required for the purpose of processing payments to verify identity and detect possible fraudulent activity.

WILL YOU CHARGE MY CARD WITHOUT NOTIFICATION?
NO. If you have health insurance, your claim will be submitted. If after your claim has been processed there is a balance due, you will be sent a bill. Our bills are due upon receipt. If payment is not received by the date indicated on the bottom of the billing statement (30 days following the statement date), the balance due will be ran to the credit card stored on file. As long as payment is received BEFORE the date indicated, your card will never be charged.

WHAT CAN BE CHARGED TO THE CARD?
Your stored card can only be used for expenses incurred at our office.

WHAT INFORMATION IS VISIBLE TO YOUR EMPLOYEES?
Your credit card information will be limited to the last four digits of the card number, and the expiration date. NO ONE IN OUR OFFICE (INCLUDING MANAGEMENT) WILL HAVE ACCESS TO YOUR CARD NUMBER. We do not keep a copy of your card or card information anywhere in our office.

WILL I RECEIVE NOTIFICATION IF MY CARD IS USED?
If you have an email address on file, you will be notified anytime your card is charged, and if there are changes made to your stored customer information. Square does a very good job of keeping you informed at all times.

CAN I USE MY STORED CARD ON FILE FOR MY OFFICE VISITS?
It is preferred that you present your actual card for payment in the office during a visit. For certain circumstances, we can use your stored card on file, but as a general rule you will always be asked to present your card for any payments.

IF I REMOVE MY CREDIT CARD ON FILE WILL I STILL BE ABLE TO BE SEEN AS A PATIENT?
If you remove your card on file we reserve the right to refuse further medical treatment as it is a violation of our billing agreement.