

Welcome to Mattison Podiatry Group

Please print and fill out completely

First Name: _____ Middle: _____ Last: _____

DOB: _____ Age: _____ Gender: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____ City/State/Zip _____

Northern Address: _____ City/State/Zip _____

Email: _____

Circle one:

Marital Status: Married Single Divorced Widowed

Race: African American Native American Caucasian Asian Hispanic Other Decline

Ethnicity: Hispanic or Latino Non Hispanic or Latino Other Decline

Preferred Language: English Spanish Other Decline

Emergency Contact: _____ Phone Number: _____ Relationship to you: _____

Employer: _____ Occupation: _____ Phone Number: _____

Primary Care Physician: _____ Last Visit: _____ Phone Number: _____

Endocrinologist: _____ Last Visit: _____ Phone Number: _____

Preferred Pharmacy: _____ Address: _____ Phone Number: _____

Primary Insurance: _____ Secondary Insurance: _____

****Medicare Patients**** What state is your Medicare coverage registered?: _____

How were you referred to our office: _____

Previous Podiatry Treatment: Y / N if yes when/why: _____

Reason for today's visit: _____

If you have health insurance please have your card(s) along with your ID available for the receptionist to copy. If we are providers under your health insurance please be aware that you are responsible for all copays, deductibles and any non-covered services today. If you do not have health insurance payment will be due today unless other arrangements have been made. Please inquire prior to treatment if you have any questions. I hereby authorize Dr Mattison to assign benefits on my behalf, and authorize the release of any medical records necessary to obtain payment from my insurance company.

Signature: _____ Date: _____

if minor, Signature of responsible party: _____ Relationship: _____

Patient Name: _____ DOB: _____

Height: _____ Weight: _____ Shoe size: _____

Recent Blood Pressure: _____ Pulse: _____

Please list all medical problems you are currently being treated for: _____

Please list all medications you are currently taking: *(including strengths and frequency)* _____

List any allergies to medication and the reaction you experienced: _____

Any other allergies: _____

SURGICAL PROCEDURES:

Any foot or ankle surgical procedures Yes or No If yes, list type of surgery and dates _____

Any other surgeries: _____

Check any of the following that apply.

Do you Smoke? Yes ___ No ___ Never ___ Previously, but quit ___ How long ago? _____ Current packs a day: _____

Do you drink Alcohol? Yes ___ No ___ Never ___ Rarely ___ Moderate ___ Daily ___

Women – Are you pregnant Yes ___ No ___ Breast feeding? Yes ___ No ___

CHECK ANY OF THE FOLLOWING CONDITIONS THAT YOU ARE BEING TREATED FOR:

DIABETES ___ TYPE 1 ___ TYPE 2 ___	BLEEDING ISSUES ___	SKIN/DERMATOLOGIC ISSUES ___
HIGH BLOOD PRESSURE ___	KIDNEY/URINARY ISSUES ___	DEPRESSION ___
HEART DISEASE ___	ARTHRITIS ___	HISTORY OF BLOOD CLOTS ___
STOMACH ISSUES ___	LIVER PROBLEMS ___	THYROID ISSUES ___
LUNG/BREATHING ISSUES ___	CANCER ___ TYPE _____	

I certify that all the information on my intake form(s) is correct to the best of my knowledge. I understand that it is my responsibility to notify the physician and/or staff of any and all updates to my information. I understand that providing incorrect information can be dangerous to my health. I hereby authorize Mattison Podiatry Group to retrieve my medical and/or medication history and perform necessary services I may need.

Signature: _____ Date: _____

If minor, Signature of responsible party: _____ Relationship: _____

Patient Name: _____ Date: _____

A WORD ABOUT INSURANCE COVERAGE

Mattison Podiatry Group appreciates the confidence you have shown in choosing us to provide your foot care needs. The insurance you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. This financial policy contains important details about billing and payments for our professional services. It outlines your responsibility concerning billing and payment for our services.

ROUTINE FOOT CARE: (cutting of nails, corns, calluses) This service is only covered by insurance when there is a medically necessary diagnosis such as (Diabetes, Blood thinners, Multiple Sclerosis, Neuropathy).

INSURANCE: Mattison Podiatry Group participates with most insurance plans, including Medicare. If we participate with your plan we will bill the insurance carrier directly and you will be responsible for co-payments, deductibles, non-covered services, ect. Please remember that your insurance coverage is a contract between you and your insurance company. Insurance policies often do not provide full payment of medical costs, and you are responsible for any services which your insurance plan does not cover. Contact your insurer directly with any questions regarding your coverage. Medicare patients are responsible for their 20 % co-insurance and yearly deductible. Having secondary insurance does not mean that your services are covered at 100%. Secondary insurance will pay based on your primary carrier. We will bill your secondary as a courtesy and you will be responsible for any balance. Our office does not bill a tertiary or third insurance company.

REFERRALS: Insurances sometimes require their members to obtain a referral for treatment from a specialist. Please be aware that it is your responsibility to obtain any referral if needed. In the absence of the required authorization or referral you will be responsible for 100% of the charges for your visit at the time of your visit.

CO-PAYMENTS: Co-Payments, coinsurance, deductible and any service not covered by your insurance plan are your responsibility, paid at the time of service.

NON PAYMENT: If your account becomes more that 90 days past due, you will be required to pay your account in full within 10 days. Payment arrangements can be made with our billing office if you are unable to pay in full.

MISSED APPOINTMENTS: If you need to cancel an appointment, please give our office as much notice as possible so that we may allow other patients to utilize the appointment.

RETURNED CHECKS: You will be charged a \$25 fee for a returned check if it is returned for non-payment/insufficient funds.

We accept: CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS and DISCOVER

I have read and understand the payment policy and agree to abide by its guidelines.

Signature _____ Date: _____
(signature of patient or responsible party)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was made aware of the Notice of Privacy Practices and can receive a copy of them at any time. I acknowledge that I have read or had the opportunity to read it if I so choose; and understand the notice.

Patient Name (please print) Date: _____

Signature

Parent or Authorized Representative (if applicable)