Patient Registration

Patient Name:_____ DOB:____/____/____

Mailing Address: _____

SSN:_____-_____-_____ Sex: Male / Female Marital Status: M / S / W / D

Patient Phone: (H)_____ (C)_____(W)_____

Employer:_____
Phone:_____

Responsible Party if other than self:

_____

Emergency Contact: _____
Relationship:_____

Phone #: _____ Privilege to Health Information/Account: Yes/No

Primary Care Physician: _____ Date Last Seen:_____

List of Medications_____

_____

_____

Medical History/Previous Surgeries:_____

_____

_____

Medication Alleriges:_____

_____

I certify that the above information is true and correct. I give my permission for the Physician to treat/diagnosis my foot condition as necessary.

Patient Signature:_____
Date:_____

AUTHORIZATION AND NOTIFICATIONS

INSURANCE AUTHORIZATION

I, the undersigned, certify that I have insurance coverage as listed on the Patient Registration Form and assign directly to North Mississippi Foot Specialists (NMFS), all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, reguardless of whether or not paid by my insurance. I hereby authorize NMFS to release all information necessary to secure the payment benefits. I authorize the use of this signiture on all insurance submissions. I further understand that if payment by any insurance is not complete by 30 days after submission, that I am fully responsible for immediate payment to NMFS. I also understand that if any portion of any account is left unpaid after 60 days, my account may be sent to an attorney or collection agnecy for collection purposes. I will be responsible for all legal fee, court cost, collection fees, and any other fees associated with my account. I understand it is my responsibility to provide referrals from my Primary Care Physician (PCP) as required by my insurance plan. I am responsible for payment of claim if claims are denied for failure to obtaim referrals from PCP.

Patient Signature _____ Date _____

SELF-PAYMENT NOTIFICATION

I understand that if I do not have insurance, I am fully responsible for immediate payment to NMFS. I also, understand that if any portion of my account is left unpaid after 60 days, my account may be sent to an attorney or collection agency for collection purposes. I will be responsible for all legal fees, court cost, collection fees, and any other fees associated with my account.

Patient Signature _____ Date _____

RECEIPT OF PRIVACY NOTICES

I understand that I was provided a copy of the "Notice of Privacy Practices" and that I have read (or had the opportunity to read if I so choose) and fully understand the "Notice of Privacy Practices".

Patient Signature _____ Date _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or Dr. Williams, Dr. Yeager, or NMFS for any services furnished to me by that physician. I authorize NMFS to release medical information about me to CMS, HCFA or its agents as needed to determine these benefits and payment of these benefits. I understand that my signature authorizes payment for services rendered. In Medicare assigned cases, NMFS agrees to accept the charge determination of the Medicare carrier as the fall charges, and I am responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductibles are based upon the charge determined by my Medicare carrier.

Patient Signature _____ Date _____