PODIATRIC REGISTRATION FORM

NAME _____ **SEX** _____ **BIRTHDATE** _____

ADDRESS _____

city **state** **zip**

HOME PHONE # _____ **WORK PHONE** _____

E-MAIL _____ **CEL PHONE** _____

OCCUPATION _____ **EMPLOYER** _____

IN CASE OF EMERGENCY, CALL

_____

NAME **RELATIONSHIP** **PHONE #**

PLEASE READ AND SIGN BELOW

ASSIGNMENT AND RELEASE: I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Dr. Michael Rosenblum all insurance benefits, if any, otherwise payable to me for services rendered. I authorize payment of medical benefits to Dr. Michael Rosenblum. 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 insurance submissions.

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Michael Rosenblum 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 or the benefits payable for related services. I understand that my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance' is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

HIPPA Privacy Practices Notice: I acknowledge that I have read/received a notice of privacy practices. ×_____initial

Medication History: I authorize the Doctor's office to retrieve my medication history. ×_____initial

Financial Policy: I acknowledge that I have read, agreed to and received a copy of the financial policy. ×_____initial

Appointment Cancellation Policy: I acknowledge that I have read, agreed to and received a copy of the cancelation policy. ×_____initial

The information on my intake form is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician/staff of any and all updates to the information listed.

I hereby give my permission to the doctor to administer and perform testing/procedures as deemed necessary for the diagnosis and treatment of my problem(s).

_____ _____

Beneficiary/Responsible Party Signature Date