

Financial Policy and Patient/Facility Agreement

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. The following is a statement of our financial policy which we require you to sign prior to any treatment.

All patients must complete our information packet and produce all insurance cards and id prior to seeing the doctor.

CUSTOM PRODUCTS (SHOES, INSERTS, ORTHOTICS, ETC.) ARE NON REFUNDABLE.

ALL returned checks have a \$25.00 processing fee applied to the account.

Non insurance patients (self pay) **full payment is due at time of service.** We accept cash, check, credit, card, etc.

Regarding insurance

We may accept assignment of insurance benefits. **ALL co pays, coinsurance and deductibles are due at the time of service.** In the event that your insurance is not in network you will be considered self pay. **The balance is your responsibility whether your insurance company pays or not.** Your insurance policy is a contract between you and your insurance company. We are not a third party to that contract. Please be aware that some, perhaps all, of the services provided may be non covered services and not considered reasonable under your insurance program.

Adult patients/Minor patients

Adult patients are responsible for their portion of payment at the time of service depending of self pay or insurance coverage. The accompanying parent or guardian is responsible for full payment. For non accompanying minors, non emergency treatment will be denied.

Insured Patients Only: Medicare and Insurance Authorization

I request that payment of authorized Medicare or insurance benefits be made to me on my behalf to Ocala Podiatry Corp for any service furnished to me by that physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents; the information needed to determine these benefits or the benefits payable for any related services. I understand my signature request that payment be made and authorizes 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 authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician, agency shown, or supplier agrees to accept the charge determination of the Medicare carrier as based upon the charge determination of the Medicare Carrier.

_____ (INITIALS)

Insured Patients Only: Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Ocala Podiatry Corp all insurance benefits, if any, otherwise payable to me for services rendered, 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 payment of my benefits. I authorize the use of this signature on all insurance claim submissions.

_____ (INITIALS)

Failure to Keep Scheduled Appointments

A 24 hours notice is required in the event you cannot keep your appointment. If notice is not given in a timely manner, there is a mandatory **\$50.00 no show fee.**

_____ (INITIALS)

Financial Policy and Patient/Facility Agreement (cont.)

Outstanding Balances Over 120 Days

I understand if I have an unpaid balance to Ocala Podiatry and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts.

In order for Ocala Podiatry or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Ocala Podiatry and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable. Furthermore, I consent to the designated external collection agency to share personal contact and account related information with third party vendors to communicate account related information via telephone, text, e-mail, and mail notification.

_____ (INITIALS)

I have read, understand and agree to this financial policy:

Printed Name: _____ Signed Name: _____ Date: _____

Notice of Privacy Act

Patient Contact

We may contact you to provide appointment reminders, treatment information, billing and payment information, or for patient satisfaction surveys.

Allowed Uses and Disclosures of Your Medical Information:

- Treatment – such as ordering diagnostic test
- Payment – such as submitting information to your insurance company
- Health Care Operations – such as quality assurance review, coordination of care, eligibility verification.

In addition to the above, your medication information may be used or disclosed for emergency treatment; when we are required by law to treat you, we attempt to obtain consent, and if we are unable to obtain consent due to substantial communication barriers and consent for treatment is implied under the circumstances or we created or received the information in treatment.

You have the right to:

- Request a restriction on certain uses and disclosures; however we are not required to agree to any requested restrictions.
- Receive confidential communication from us, upon written request.
- Inspect and request copies of your medical information.
- Request to amend copies of your incorrect or incomplete medical information.
- Receive an accounting of any disclosures made, upon written request.
- Receive a paper copy of the notice upon request.

We are responsible for:

- Maintaining the privacy of your medical information.
- Providing you this notice.
- Abiding by the terms of this notice.
- Providing written notice of any change to this notice.

Printed Name: _____ Signature: _____ Date: _____

Authorized Representative Designation Form

Patient Information

Full Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____ Last 4 of SSN (optional):

Authorized Representative Information

Ocala Podiatry Corporation, 5481 SW 60th St unit 502, Ocala, FL 34474

Relationship to patient: Medical Provider- Podiatry

Scope of Representation

I hereby authorize the above-named individual or organization to act as my Authorized Representative for the purpose(s) of (check all that apply):

- Requesting and receiving my protected health information (PHI)
- Discussing my medical care and treatment plans
- Handling billing or claims-related matters
- Submitting appeals or grievances on my behalf
- Other (specify): _____

This authorization permits my provider(s) and their staff to communicate and release information to my Authorized Representative as necessary to carry out these functions.

Limitations or Conditions (optional)

Expiration of Authorization

This authorization will remain in effect until (select one):

- _____ (specific date)
- Revoked by me in writing
- Completion of the matter for which this authorization was given

Patient Acknowledgement

I understand that:

- I may revoke this authorization at any time by submitting a written request.
- Revocation will not affect any disclosures made before it is received.
- Information disclosed to my Authorized Representative may no longer be protected by federal privacy rules.
- Signing this form is voluntary. My treatment, payment, or benefits will not be affected by my decision.

Signatures

Patient Signature: _____ Date: _____

Authorized Representative Signature (optional): _____ Date: _____

Witness (if required): _____ Date: _____



OCALA PODIATRY

DR. ANDREW FRANKLIN DPM, PhD

Date: _____

Patient Name: _____ Nickname: _____

DOB: _____ SS#: _____

Gender: Male Female

Home Address: _____ City: _____

State: _____ Zip Code: _____

Phone number: _____ Email: _____

Race:

- | | | |
|---|---|---|
| <input type="checkbox"/> American Indian/
Alaskan Native | <input type="checkbox"/> Black/African
American | <input type="checkbox"/> Native Hawaiian/
Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Hispanic/ Latino | <input type="checkbox"/> White |
| <input type="checkbox"/> Black/African
American | <input type="checkbox"/> Native Hawaiian/
Pacific Islander | <input type="checkbox"/> Unknown |
| | | <input type="checkbox"/> Decline to answer |

Emergency Contact:

Name: _____

Contact Phone #: _____

Relation to Patient: _____

Name: _____

Height: _____ Weight: _____

Primary Care Physician: _____ Date last seen: _____

Pharmacy: _____

Pharmacy Address: _____ Tel: _____

Have you seen Dr Franklin in the past? Yes No If yes when? _____

Medical History:

Diabetes:

- | | | |
|---------------------------------|--|--|
| <input type="checkbox"/> Type 1 | <input type="checkbox"/> Insulin Dependent | <input type="checkbox"/> Diet controlled |
| <input type="checkbox"/> Type 2 | <input type="checkbox"/> Oral medication | |

Please check all those that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Dementia | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Myocardial infarction |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Benign prostate hyperplasia | <input type="checkbox"/> GERD | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Renal stones |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Gout | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Headaches | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid disease |
| | | <input type="checkbox"/> Ulcer (GI) |

Other: _____

Medications:

Please list all medications you are taking (you may also provide list to front desk to scan):

Allergies:

Please check all those that apply:

- | | | |
|--------------------------------------|----------------------------------|--|
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Seafood | <input type="checkbox"/> Influenza Vaccine |
| <input type="checkbox"/> Egg Derived | <input type="checkbox"/> Gluten | <input type="checkbox"/> Lactose |

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> Latex | <input type="checkbox"/> Peanut | <input type="checkbox"/> Neosporin/Triple Antibiotics |
| <input type="checkbox"/> Betadine/Iodine | <input type="checkbox"/> Penicillins | |
| <input type="checkbox"/> NSAIDs (Ibuprofen) | <input type="checkbox"/> Sulfa | |

Other: _____

Social History:

Cigarette/tobacco: Yes No

- | | |
|--|---|
| <input type="checkbox"/> Current smoker/tobacco user | <input type="checkbox"/> Former smoker/tobacco user |
| <input type="checkbox"/> Type _____ | <input type="checkbox"/> Quit Date: _____ |
| <input type="checkbox"/> Pack(s) per day: _____ | |

Alcohol: Yes No

- | | | |
|---------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Beer | <input type="checkbox"/> Wine | <input type="checkbox"/> Liquor |
| <input type="checkbox"/> Amount _____ | <input type="checkbox"/> Amount _____ | <input type="checkbox"/> Amount _____ |

Recreational Drugs:

Do you take any recreational drugs?: Yes No

If so, what?: _____ How Often?: _____

Family Medical History:

Mother Living: ___ Mother Deceased: _____ Cause of Death: _____ Age: _____

Any significant medical history (e.g. Diabetes, Cancer etc.)?: _____

Father Living: ___ Father Deceased: ___ Cause of Death: _____ Age: _____

Any significant medical history (e.g. Diabetes, Cancer etc.)?: _____

Immunization History

- | | | |
|--|--|--|
| <input type="checkbox"/> Influenza.
Date: _____ | <input type="checkbox"/> Pneumonia.
Date: _____ | <input type="checkbox"/> Tetanus.
Date: _____ |
|--|--|--|

Prior Surgeries

Please check all those that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> Angioplasty (PVD) | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> CABG |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Breast Augment | <input type="checkbox"/> Carotid Endarterectomy |

- | | | |
|--|--|--|
| <input type="checkbox"/> Cataract Extraction | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Shoulder Surgery |
| <input type="checkbox"/> Cesarean Section | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Sinusotomy
(Nasal) |
| <input type="checkbox"/> Colectomy | <input type="checkbox"/> Knee Arthroscopy | <input type="checkbox"/> Splenectomy |
| <input type="checkbox"/> Duodenal Ulcer | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Thyroidectomy |
| <input type="checkbox"/> Fracture | <input type="checkbox"/> Lasik | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Gastric Banding | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Heart Valve | <input type="checkbox"/> Prostate Surgery | <input type="checkbox"/> Vein surgery |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Shoulder
Arthroscopy | |
| <input type="checkbox"/> Hip Fracture | | |

Other: _____

Podiatric History:

Please check all those that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Foot/Ankle
Fracture | <input type="checkbox"/> Neuroma Removal |
| <input type="checkbox"/> Biopsy | <input type="checkbox"/> Hammer Toe | <input type="checkbox"/> Tendon Surgery |
| <input type="checkbox"/> Bone Spur
Removal | <input type="checkbox"/> Heel Spur Removal | <input type="checkbox"/> Plantar Fascial
Release |
| <input type="checkbox"/> Bunion Correction | <input type="checkbox"/> Toenail Surgery | <input type="checkbox"/> Wart Procedure |

Consent:

I certify that the above information is correct to the best of my knowledge, I give permission to Dr. Andrew Franklin to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature: _____ Date: _____