PATIENT REGISTRATION

Patient's Name:_____ _____ _____ **Preferred Name:**_____
First MI Last

Mailing Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone: _____ **Cell :**_____ **Email:**_____

Birthdate:_____ **Age:**_____ **Gender:** M / F **Social Security:**_____

Employed: ▫ Full-time ▫ Part-time ▫ Not employed ▫ Retired **Position:**_____

Employer:_____ **Address:**_____ **Phone#:**_____

Marital Status: ▫ Single ▫ Married ▫ Divorced ▫ Separated ▫ Widowed **Who do you live with?**_____

Spouse Name:_____ **Phone :**_____

Emergency Contact :_____ **Phone:**_____

How did you hear about our office? Newspaper Yellow pages Radio Friend/relative Insurance Physician

If referred by physician, please list name _____

Primary Care Physician_____ **City**_____ **Date Last Seen**_____

INSURANCE INFORMATION

Primary Insurance Company:_____ **ID#** _____ **Group#**_____
Effective Date:_____ **Do you have a copay?** ▫ No ▫ Yes, Amt $_____

Policy Holder Name:_____ **DOB:** _____ **SS#:**_____

Patient Relationship to Policy Holder: ▫ Self ▫ Spouse ▫ Child ▫ Other

Secondary Insurance Company:_____ **ID#** _____ **Group#**_____
Effective Date:_____ **Do you have a copay?** ▫ No ▫ Yes, Amt $_____

Policy Holder Name:_____ **DOB:** _____ **SS#:**_____

Patient Relationship to Policy Holder: ▫ Self ▫ Spouse ▫ Child ▫ Other

Responsible Party *Please complete if the responsible for payment is NOT the Patient or the Policy Holder. For example if the patient is under age 18.*

Guarantor's Name:_____ **Relation to Patient:**_____ **DOB:**_____

SS#_____ **Address** (if different):_____

The above information is accurate and complete to the best of my knowledge and is only in use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand responsibility for payment is mine, payable at the time service is rendered. I further understand attorney fees, court costs and collection fees incurred in the collection of this account are my responsibility. I also assign insurance benefits to the doctor.

Signature:_____ **Date:**_____

First _____ MI _____ Last _____ Preferred Name _____ Job Activity/Occupation _____

Birth Date _____ Sex **M / F** Age _____ Height _____ Weight _____ Shoe Size _____

Medications:
Please list:

	Dose?How Often? (daily/weekly)	For Treatment of?
_____	___x ☐/☐	_____
_____	___ x ☐/☐	_____
_____	___ x ☐/☐	_____
_____	___x ☐/☐	_____
_____	___x ☐/☐	_____

Preferred Pharmacy:
_____
City: _____

Allergies (such as latex, adhesive Tape, antibiotics, Iodine):_____
_____
_____
_____

List relationship of family members who have had:
Diabetes:_____ Foot Problems:_____
Arthritis: _____ Heart Attack: _____
Stroke: _____ High Blood Pressure:___
Cancer: _____ Birth Defects: _____

if childbirths _____ Currently Pregnant? ☐ Yes ☐ No
Are you slow to heal after cuts? ☐ Yes ☐ No
Do you smoke now? ☐ No ☐ Yes Packs/day ____ Years ____
Did you ever smoke? ☐ No ☐ Yes Packs/day ____ Years ____
If you quit when did you do so? _____
Alcoholic Beverages: (circle one) None Rarely Moderately Daily Quit

Does foot pain limit your desired activities? ☐ Yes ☐ No
Do you have any difficulty in walking? ☐ Yes ☐ No
Any pain in calves or buttocks when walking? ☐ Yes ☐ No
Is the pain relieved by stopping & standing still? ☐ Yes ☐ No

Did you previously or do you now wear:
Shoe Inserts? _____ Did they help? _____
Orthotics? _____ Did they help? _____

List the sports/dance you are active in:
_____

Are your first steps out of bed painful? ☐ Yes ☐ No ... then subsides? ☐ Yes ☐ No
Do you get leg cramps...during the day? ☐ Yes ☐ No ...at night? ☐ Yes ☐ No
Percent of waking hours spent on your feet? (circle one) 20% 40% 60% 80% 100%
Do you have grafts, implants, or heart valves? ☐ Yes ☐ No
Have you had any other serious illness? ☐ Yes ☐ No
Have you had any surgery or hospitalizations? (if yes, please list below)

Surgery/Hosp. For?	Date	Complications?
_____	_____	_____
_____	_____	_____

Do you have or have you ever been treated for:

☐ Stroke	☐ Heart Attack	☐ High Blood Pressure
☐ Vascular Disease	☐ A Heart Condition	☐ Anemia
☐ Poor Circulation	☐ Diabetes	☐ Eyes: Glaucoma/Manicular Deg.
☐ Kidney Disease	☐ Keloid/ Thick Scar	☐ Gout
☐ Osteoporosis	☐ Alzheimer's	☐ Sciatica
☐ Lyme's Disease	☐ Rheumatic Fever	☐ Arthritis
☐ Headaches	☐ Hearing/Ear Disorder	☐ Epilepsy
☐ Nerve Disorder	☐ Psychiatric Disorder	☐ Asthma
☐ Lung Disease	☐ Tuberculosis	☐ Hepatitis
☐ HIV	☐ Liver Disorder	☐ Thyroid Problem
☐ Chronic Light Stool	☐ Cancer	☐ Stomach Ulcer
☐ Unexplained Weight Loss	☐ Others: _____	

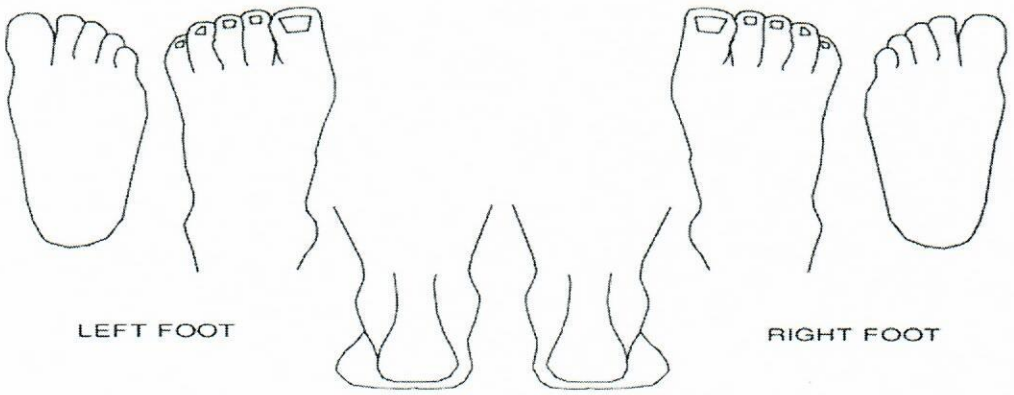
☐ NONE of These

Anything else that you want to tell the doctor? ☐ Yes ☐ No

_____

_____

Family/Primary Physician: _____ City: _____ Date Last Seen: _____



Please mark the location of your first problem or pain on the diagrams above with a **1.**

Describe your problem below and its cause if you know. Please describe associated pain to the right. ➡

My first problem is... ☐ Left ☐ Right ☐ Both

It causes me difficulty: ☐ Walking ☐ Wearing Shoes

And/Or: _____

_____

Is the problem work related? ☐ Yes ☐ No

How long ago did the problem start? _____

Is your pain/discomfort:

☐ None ☐ Light ☐ Moderate

☐ Strong ☐ Severe

****

☐ Shooting	☐ Throbbing
☐ Sharp	☐ Burning
☐ Dull	☐ Itching
☐ Aching	☐ Tenderness
☐ Tingling	☐ Numbness

Previous treatments/remedies?

_____

Are there any other problems? _____

Signature: _____ Date: _____

Billing Policies for Dr. James Graham

We will bill your insurance as a courtesy at the time of your initial visit, a new patient is required to pay in full the charge for the office visit and additional charges (x-rays, procedures, etc.) unless the patient has insurance with A COPAY or a percentage of the total charges required. Financial agreements may be set up with the office manager should this not be possible. Statements will be mailed on a monthly basis, with all balances reflecting payments made throughout the month.

This office will bill each patient's primary insurance carrier. Patients should be aware of their insurance coverage and be able to estimate the amount of charges that the insurance company will determine to be the patient's share. That amount should be paid upon the receipt of each statement. Despite this, the patient is responsible for the entire balance due regardless of whether the insurance company is billed or pays any portion of the balance. Payment in full is expected in three months. An interest charge of 1.5% will be added after charges are outstanding for longer than 60 days.

Insurance policies are CONTRACTUAL AGREMENTS between PATIENTS AND INSURANCE COMPANIES. We are, therefore, not able to answer questions regarding specific coverage, but will offer assistance in understanding of any activity by the insurance company reflected in the patient's account. It is not our policy or our responsibility to contact insurance companies to determine coverage in advance or to establish the reasoning behind insurance payments which are less than expected. Patients should keep in touch with their insurance companies to determine the status of any unpaid claims which have been billed by our office. Also, it is the patient's responsibility to question this office participation in any HMO's or PPO's. We are not responsible for any restrictions or requirements set forth by any HMO's or PPO's if we are not under contractual agreement with the company.

If you are claiming a Workers Comp case against your employer, you much have the name of the Insurance Company, claim number, and a contact person. If you do not have this information YOU will be responsible for the account.

This office DOES NOT accept Medicaid patients. Patients will be responsible for the balance in full at the time of the visit.

RESPONSIBLE PARTY: We understand court decisions sometimes mandate responsible party following a divorce. In situations such as this, we ask that the representing parent/party pay for the co-payment/deductible at the time of the service. We will provide a receipt for reimbursement purposes.

There may be FEE for the completion of disability forms, mortgage forms, auto insurance forms and bank forms of all types. Similarly, a fee will be assessed for the provision of copies of medical records in certain circumstances. These fees must be paid before the forms are completed. We regret this additional charge, but the number of forms completed has become overwhelming and requires considerable staff time.

This office DOES NOT participate in fraudulent practice of writing off the amount considered to the patient's portion after payment has been received from the insurance company.

In the event your account becomes past due, it may be turned over to a collection agency and/or attorney for collection. If your account is not paid in full and this account is turned over to a collection agency and/or attorney, they you agree to be responsible for all reasonable fees necessary for the collection of the delinquent account including, but not limited to, collection agency fees of 50% of the balance due and costs and reasonable attorney fees of 33% of the balance due.

By signing below, (1) you promise to pay the account; (2) state that you are the patient or legal guardian or parent of the patient; (3) you authorize and direct all insurance companies to send payment directly to James C. Graham, DPM; (4) agree if any insurance company pays you directly for services you will pay the money immediately to Dr. Graham; (5) if you fail to promptly pay the balance in full, provider may employ an attorney or collection agency to collect the balance due and legal fees and expenses will be added to the account balance owed. If you have any questions regarding our office policies or wish to make special billing arrangements, please feel free to contact our office manager.

"I have read this entire form and the terms contained in it and believe I understand it. I am signing it of my own free will and authorize the Provider to release medical information from my file for any reasonable purpose involving the processing of claims/payments."

_____ _____

Signature of Responsible Party for this Account **Date**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge 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 chose) and understood the Notice.

_____ _____

Patient Name (please print) **Date**

_____

Signature

_____

Parent or Authorized Representative (if applicable)

ACKNOWLEDGEMENT/AGREEANCE AND RECEIPT OF BILLING POLICIES

"I have read the entire form and the terms contained in it and believe I understand it. I am signing of my own free will and authorize the Provider to release medical information from my file for any reasonable purpose involving the processing of claims/payments."

_____ _____

Signature of Responsible Party for this Account **Date**

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of person(s) that can obtain information about your medical history/information or your account/billing information. I understand the person(s) listed below will be the ONLY individuals to be able to obtain medical and/or account information.

NAME	RELATIONSHIP	MEDICAL	BILLING
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____

Patient Signature **Date**

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices.

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.