Southern Maryland Foot & Ankle **Account #** _____

First Name: _____ **MI:** _____ **Last Name:** _____ **Gender:** Male **or** Female

Mailing Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Date of Birth:** ____/____/_____ **Social Security #:** _____-____-_____

Best Contact # :(____) _____-_____ **E-mail:** _____

___ OK to leave message with detailed information
___ Leave message with call back numbers only
____ OK to e-mail health information
____ NOT ok to e-mail health information

Primary Care Physician (first and last name): _____ **Phone:** _____

Do you or have you ever had an infectious disease? Yes or No (Please circle) Hepatitis, HIV, AIDS, MRSA

Were you referred by a physician? Yes **or** No, If yes, which Doctor? _____

_____

Primary Insurance: _____
Are you the sponsor of this insurance? YES/NO
If not, please provide the following:
Spouse/Parent Name: _____
Date of Birth: _____/_____/_____

Secondary Insurance: _____
Are you the sponsor of this insurance? YES/NO
If not, please provide the following:
Spouse/Parent Name: _____
Date of Birth: _____/_____/_____

_____

Reason for your visit today: _____

Any past foot/ankle surgery or problems? If yes, please list: _____

Do you have diabetes? YES **or** NO **If yes:** TYPE I **or** Type II **Controlled By:** Insulin/Oral Medication/Diet

Smoker: (Please circle) Every day Smoker **or** Former Smoker **or** Non-Smoker

Did you receive a Flu shot this season (October-March)? YES **or** NO

If you are 65 years of age or older, have you received a Pneumonia vaccine? YES **or** NO

Which Pharmacy do you use: _____ **City:** _____ **Street:** _____

Current Medical Conditions: _____

_____

Medications that you are taking: _____

_____

Are you allergic to any medications? Please list medication and reaction: _____

_____

SOMD Foot and Ankle Guidelines

Co-pays and balances are due at the time of service. We will bill only two contracted insurance companies; however, you are ultimately responsible for all charges whether the insurance company paid for your claim or not. The insurance companies you place on this form are the carriers we will bill for your date of service. I hereby authorize SOMD Foot and Ankle and staff to disclose my individually identifiable health information to the insurance carrier(s). SOMD Foot and Ankle will use and disclose my health information in order to obtain payment to the doctor for services rendered and allow insurance companies to process claims. I understand that this authorization is voluntary

I hereby authorize the Physicians at Southern Maryland Foot & Ankle to render treatment and/or therapy to myself that they deem medically necessary in order to treat my condition(s). My signature confirms that I have given SOMD Foot & Ankle all past and current health information and that it is accurate to the best of my knowledge.

Our office charges a $75.00 fee for missed appointments and late cancellations.
We give a COURTESY appointment reminder call, text or email 48 hours in advance.

Signature of Patient/Guardian: _____ **Date:** _____

Southern Maryland Foot & Ankle

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Account # _____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.
(Please look on clip board or in binder for copy of HIPAA)

On occasion, it may be necessary to release clinical information to outside physicians, radiological institutions, laboratories or physical therapy centers that you have been referred to, by Southern Maryland Foot & Ankle, to aide in your coordination of care. We will not release your information to any third parties.

Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:
I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Print Name:_____ D.O.B. _____
Print Name:_____ D.O.B. _____
Print Name:_____ D.O.B. _____

_____ _____
Patient Signature Date

_____
Relationship to patient (if not self)

9135 Piscataway Road
Suite 235
Clinton, MD 20735
Phone: (301) 868-3899
Fax: (301) 868-3506

Medical Director: Larry Hotchkiss, DPM
Justin Pointer, DPM
Amin Jahedi, DPM

SOUTHERN MARYLAND
FOOT & ANKLE

12070 Old Line Center
Suite 110
Waldorf, MD 20602
Phone: (301) 843-9581
Fax: (301) 843-0921

Practice Administrator: Jelena Draheim, CPM

Southern Maryland Foot and Ankle Payment Policy

Southern Maryland Foot and Ankle is a private medical organization which receives no financial assistance from state or federal programs and which relies solely on revenue from patients and their insurers. We believe that the physician-patient relationship is strengthened when there is a clear understanding between both parties as to their rights and obligations.

In order to maintain financial stability in the current medical insurance environment and to provide the best possible medical care at the lowest possible cost, we have established the following payment policies:

If Southern Maryland Foot and Ankle participates in your insurance plan

- Copayments are required at registration.
- Payment for charges from earlier visits not covered by insurance is due at registration.

If Southern Maryland Foot and Ankle does NOT participate with your insurance plan

- Payment of all unpaid balances on your account is required at registration.
- Payment in full for your visit charges is required at discharge.

If you do not have insurance

- Payment of all unpaid balances on your account is required at registration.
- Payment in full for your visit charges is required at discharge.

Authorization to keep credit card on file for balances under $50.00

I, _____, authorize Southern Maryland Foot and Ankle to charge my credit card for any outstanding patient responsible balances **AFTER** applicable insurance reimbursements have been applied for medical services received. Your card will be charged on the 14th of the month. All card information is kept confidential and secure.

Relationship to the patient: ☐ Self ☐ Parent/Guardian ☐ Other: _____

Check one: ☐Visa ☐MasterCard ☐Discover ☐American Express

Last 4 Digits of my Credit Card: _____ Exp. Date (mm/yy): _____ / _____

- If your balance is over $50 you will receive a courtesy call to confirm this is the card you would like to use or to set up a payment plan.

- Declined transaction/closed account:

    - You will be notified by phone by our billing department to provide alternate card for payment.
    - A $50 penalty will be added to all accounts if no alternative payment is provided.
    - An additional monthly late fee charge of $25 will also be applied to any account that is 30 days past the failed transaction date.

Signature: _____ Date: _____

Printed Name: _____ Name of Patient: _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Southern Maryland Foot and Ankle in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH transaction being rejected for Non-Sufficient Funds (NSF) I understand that Southern Maryland Foot and Ankle may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.