www.beverlypodiatry.com

BEVERLY PODIATRY

Timothy J. Tobin, D.P.M.*/** • Lawrence E. McGinness, D.P.M.* • Rebecca R. Calder-Kelly, D.P.M.*/** • Matthew A. Peter, DPM

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Patient Information Sheet – Confidential

Name _____ **Sex** _____ **Date of Birth** _____

Address _____ **Age** _____

City _____ **State** _____ **Zip Code** _____

Phone: ( ) - Email Address _____

Insurance _____ **ID#** _____

Emergency Contact _____ _____ **Phone (** ____ **)** ____ **-** _____

Relationship _____

Pharmacy Information: **Pharmacy Name** _____

Address _____ **City** _____ **State** ____ **Zip** _____

Primary Care Information: **Name**_____

Address _____ **City** _____ **State** _____ **Zip** _____

Last PCP visit? _____

Medical Information

Are you Diabetic? Yes _____ **No** _____ **Good Health?** _____ **Allergies** _____

What is your present foot Problem? _____

_____

When did it begin? _____

What caused the problem or makes it worse? _____

Have you ever had any injuries or operation on your feet or legs? _____

Consent for Treatment

With my signature, I request and consent to receive medical treatment that is deemed necessary for my foot health. I understand that Beverly Podiatry Podiatrists will proceed with routine diagnostic procedures and treatment upon council, discussion and mutual agreement.

Signature _____ **Date** _____

*A.B.F.A.S. Board Certified in Foot Surgery

**Fellow, American College of Foot & Ankle Surgeons*

NAME _____

BEVERLY PODIATRY AUTHORIZATIONS SIGNATURE PAGE*/**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

By signing below, I authorize Beverly Podiatry to release of any medical or other information necessary to process my insurance claim(s). I also authorize payment of my insurance and/or Government Benefits be made directly to Beverly Podiatry which include but not limited to Timothy J. Tobin, D.P.M., Lawrence E. McGinness, D.P.M. Rebecca R. Calder, D.P.M. and Matthew A. Peter, D.P.M. whom accept assignments.

Signature _____ Date _____

NON-COVERED SERVICES WAIVER/NOTICE OF FINANCIAL LIABILITY

I accept full financial liability for all items or services determined by my health care service plan which are deemed patient's responsibility. Services not specified as being covered in patient's contract, charges that occur because of missing referrals, deductibles, copays, coinsurance, or because the patient is considered out of network. I understand and agree that it is my responsibility and obligation to obtain a referral if required, and to follow up with my Primary Care Physician Referral Department to be sure my referral has been sent in a timely manner.

Signature _____ Date _____

NOTICE OF HEALTH PRIVACY PRACTICES

I acknowledge that I have been offered and understand Beverly Podiatry's NOTICE OF PRIVACY PRACTICES. This notice describes how we use/disclose your healthcare information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected information. I understand that this Notice of Privacy Practices is available should I wish to take one home with me.

Signature _____ Date _____

MEDICAL HISTORY AUTHORIZATION

By signing below, I authorize Beverly Podiatry to have access to my medical records which includes my medical history and medications, as required for treatment and documentation.

Signature _____ Date _____

*If minor, please have parent/guardian sign.

** It is policy to require all 4 signatures to be seen here at Beverly Podiatry.