ADVANCED FOOT & ANKLE CENTER, S.C.

Jeff K. Chism, DPM

PODIATRIC REGISTRATION FORM

Main office: 715-536-7444 / Fax: 715-536-1547

Patient Name: _____ **Date of Birth**: _____

Sex: Male/Female

Soc. Sec. #: _____

Guardian Name: _____ **PHONE:** _____HOME/CELL/WORK
(if applicable) Leave a message: Yes No

Address: _____ Alt. Phone: _____ HOME/CELL/WORK
Leave a message: Yes No

City: _____ **State:** _____ **Zip:**_____ **Email:** _____

Race: Ethnicity: Preferred Language:

AUTHORIZATION FOR TREATMENT AND RECEIPT OF PRIVACY PRACTICES:

I certify that all information is true and correct to the best of my knowledge. I further certify that **all answers given by me during the course of my exam will be true and correct to the best of my knowledge**. **I authorize Dr. Chism and his staff** to disclose any information from my medical records relating to my diagnosis, prognosis or treatment compiled during my medical treatment to whomever they deem it necessary, from today's date until January 1, 1965. **I give my permission** to Advanced Foot & Ankle Center, S.C. and staff to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet. I attest to the fact that I seek this medical care under my own free will and that I will ask any and all questions that I want answered before any treatment is performed. I understand that there are risks involved with this treatment and that I will obtain a full understanding and accept these risks prior to me allowing these treatments to be performed. Advanced Foot & Ankle Center, S.C. has my **permission to obtain from other providers such medical records as are necessary for treatment.**

I also acknowledge that **I have received a copy of Advanced Foot & Ankle Center, S.C.'s Notice of Privacy Practices**. Also, that I have read or had the opportunity to read(if I so choose) and understand the Notice.

Responsible Party Signature (1) _____ Date:_____

INSURANCE ASSIGNMENT AND RELEASE:

I, the undersigned, certify that I (or my dependent) have **insurance coverage** with the following company and assign directly to Advanced Foot & Ankle Center, S.C. 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 Advanced Foot & Ankle Center, S.C. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. If I fail to pay any portion of my bill and I am turned over to a collection agency, I understand that I must pay Advanced Foot & Ankle, Center, S.C. in full and I must also pay the collection agency its fee for collecting this money in addition to all money owed to Advanced Foot & Ankle, S.C.

Responsible Party Signature (2) _____ Date:_____

MEDICARE/MEDICAID AUTHORIZATION AND WAIVER OF LIABILITY:

I request that **payment of authorized Medicare/Medicaid benefits by made to me or on my behalf to Advanced Foot & Ankle Center, S.C**. For any services furnished to me by that clinic. 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 my signature requests 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 any other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare/MA assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/MA carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determined by the Medicare/MA carrier.

Responsible Party Signature (3) _____ Date:_____