Michael R. Haag, DPM, ATC, LLC **DATE**_____

5311 Limestone Road, Suite 203 Wilmington, Delaware 19808

PATIENT INFORMATION:

NAME_____

ADDRESS_____**TOWN**_____**STATE**_____**ZIP**_____

TELEPHONE HOME_____**WORK**_____ **CELL**_____

DATE OF BIRTH_____ **S.S. #** _____

GENDER: ( ) M ( ) F RACE: _____ **ETHNICITY:** _____

MARITAL STATUS: ( ) SINGLE ( ) MARRIED ( ) WIDOWED ( ) DIVORCED (SPOUSE NAME_____**)**

EMPLOYED: ( ) FULL-TIME ( ) PART-TIME ( ) RETIRED ( ) UNEMPLOYED

STUDENT: ( ) FULL-TIME ( ) PART-TIME

EMPLOYER NAME_____ **PHONE**_____

EMPLOYER ADDRESS_____

PRIMARY INSURANCE_____ **EMPLOYER**_____
ADDRESS_____
POLICY NUMBER_____**GROUP NUMBER**_____
POLICY HOLDER_____**DATE OF BIRTH**_____

SECONDAY INSURANCE_____ **EMPLOYER**_____
ADDRESS_____
POLICY NUMBER_____**GROUP NUMBER**_____
POLICY HOLDER_____**DATE OF BIRTH**_____

CHAMPUS ( ) ACTIVE ( ) RETIRED ( ) DECEASED BRANCH OF SERVICE_____

FAMILY PHYSICIAN_____ **REFERRED BY**_____

RESPONISBLE PARTY (PERSON RESPONSIBLE FOR MEDICAL PAYMENT)

NAME_____
ADDRESS_____
PHONE (HOME)_____**(WORK)**_____
DATE OF BIRTH_____**S.S. #**_____
MARITAL STATUS ( ) SINGLE ( ) MARRIED ( ) WIDOWED ( ) DIVORCED
EMPLOYER_____
ADDRESS_____

PATIENT RELATIONSHP TO THE RESPONSIBLE PARTY (CIRCLE ONE)

SELF SPOUSE CHILD STEP CHILD

FOSTER CHLD GRANDPARENT OTHER_____

REASON BEING SEEN TODAY_____

- OVER –

MEDICAL INFORMATION AND PAYMENT RELEASE/FINANCIAL RESPONSIBILITY and ELECTRONIC RETRIEVAL OF MEDICATION HISTORY

I authorize the release of medical information to my insurance carrier(s) and/or their agents. I also authorize payment of the medical benefits to be made directly to Michael R. Haag, DPM, ATC, LLC. I understand that payment is due at the time service is rendered to me, unless my insurance company is being billed for services provided. I understand that I am responsible for payment if my insurance company does not cover my balance. I understand that all co-payments are due at the time service is provided.

To help ensure proper prescribing of your mediation please read below and check one of the following:
I consent to the electronic retrieval of my current medication history from my prescription carrier(s) ( )
I do not consent to the electronic retrieval of my current medication history from my prescription carrier(s) ( )

SIGNATURE_____ DATE _____
RESPONSIBLE PARTY, PARENT/GUARDIAN IF UNDER 18 YEARS OF AGE

MEDICARE PATIENTS

I have been notified by my physician that routine foot care; including the trimming of nails and the cutting of corns and calluses is a non-covered service of Medicare, unless I am actively under the care of my primary or specialty physician for a systemic disease/condition which meets Medicare coverage guidelines. I agree to be personally and fully responsible for payment at the time of visit for routine foot care.

I have been notified that miscellaneous medical supplies, appliances, and surgical shoes are not covered by Medicare.

SIGNATURE_____ DATE _____
Beneficiary

OFFICE FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

You must realize, however, that:

1. **Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.**

2. **Not all services are a covered benefit in all contracts. It is your responsibility to know how your medical benefits work and whether or not referrals and prior authorizations are required for your medical care.**

3. **Insurance cards, and valid referrals are required at the time of your visit otherwise we have the right to reschedule your appointment.**

4. **Payment for services rendered are expected at the time service is rendered unless your insurance carrier is being billed or an arrangement has been made prior to the visit.**

5. **Co-payments and/or co-insurance amounts are due at the time of the visit.**

6. **As the responsible party you understand that this account is subject to additional collection/court/administrative fees if this account becomes delinquent.**

SIGNATURE_____DATE_____
Responsible party, parent, guardian (if under 18 years of age)