Jerlin Podiatry, LLC
808 Battlefield Blvd S, Chesapeake, VA 23322
(757)-389-7367

Patient's Name	Date of Birth	Today's Date
	/ /	/ /

HIPPA ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 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 understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare 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.

Signature	Relationship to Patient

Please Read Carefully

We provide the best possible care for you and want you to completely understand our policies.

INSURANCE POLICIES

Please keep in mind that your insurance policy is a contract between you and your insurance company. We cannot assume that any specific charge will be covered. Your involvement in knowing what your plan covers is important, and we encourage you to become familiar with your plan. This information is best obtained by calling your insurance company.

Co-payments, deductibles and non-covered fees are the responsibility of the patient. They are due at the time of service.

We file primary and secondary insurance claims for our patients. If a service is considered "not covered" by your insurance company, the patient will be responsible for the charge. If you do not agree with the denial, you must resolve the matter with your insurance company. Payment is due upon receipt of a statement from our billing office.

To be seen by a specialist, **Medicare & Medicaid insurances requires that you are seen every 6 months, by a primary care doctor,** whom is treating your primary condition. Medicare & Medicaid requires specialists, when filing your claim, we must include the name of your primary doctor and the last date you saw this doctor. Without this information, Medicare & Medicaid will deny payment.

REFERRALS

Please note that if your plan requires a referral, it is the patient's responsibility to obtain one and it must be presented at the time of service. If you do not have one, then you will have to reschedule your appointment until the time that you obtain a referral. If you choose to see a doctor without the required referral, you may become responsible for payment in full, should your insurance company deny your claim.

SELF-PAY

A Self-Pay Patient is defined as a patient who has no health insurance coverage of any kind, is not eligible for worker's compensation coverage; and has no other responsible party covering the expenses associated with the care received from our clinic.

Self-pay patients will be required to pay a $50.00 deposit towards the cost of the visit, at time of service. If additional charges, such as x-rays, are incurred, a 25% discount will be assessed to the patient balance. If the balance is not paid in full, arrangements must be made with our Billing Office (757)-389-7367. Self-Pay patients are required to make regular payments and will forfeit the Self-Pay discount if they fail to make all required payments due under the Payment Plan.

APPOINTMENT POLICY

If, for any reason, you are unable to keep your appointment, please call our office at least 24 hours in advance. Failure to cancel an appointment without sufficient notice will result in a $25 charge to your account. The fee is not covered by any medical insurance.

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Patient's Name	Date of Birth	Today's Date
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Primary Physician	Last Visit Date	Did He/She request you be seen?
	/ /	□ Yes □ No

What brings you to the office to been seen?

MEDICAL HISTORY

□ AIDS/HIV	□ Chemical Dependency	□ Hepatitis or Jaundice	□ Respiratory Disease
□ Allergies Anesthetics	□ Circulatory Problems	□ High Blood Pressure	□ Scarring Tendency
□ Allergies to Medicine	□ Diabetes	□ Joint Pain or Stiffness	□ Shortness of Breath
□ Anemia	□ Epilepsy	□ Kidney Problems	□ Sickle Cell Anemia
□ Angina	□ Foot or Leg Cramps	□ Liver Disease	□ Stroke
□ Arthritis	□ Foot or Leg Numbness	□ Low Blood Pressure	□ Swelling of Ankles, Feet
□ Artificial Heart Valves	□ Gout	□ Nervous Problems	□ Thyroid Problems
□ Asthma	□ Headaches	□ Phlebitis	□ Tuberculosis
□ Back Problems	□ Hearing Aid(s)	□ Psychiatric Care	□ Ulcers/Stomach Problem
□ Bleeding Disorders	□ Heart Disease	□ Radiation Treatment	□ Varicose Veins
□ Cancer	□ Hemophilia	□ Rash	□ Weight Loss, Unexplained

Weight: _____	Smoker:	Alcohol Use:	□ Metal Implants
	□ Never	□ Never	Location: _____
Height: _____	□ Past	□ Past	□ Body Piercings
	□ Current, Packs/Day___	□ Current, Drinks/Day_____	Location: _____

Female Patients:
Are you pregnant? □ Yes □ No Do you take contraceptives? □ Yes □ No If Yes, specify_____

ALLERGIES

□ No Known Drug Allergies

□ Adhesive/Tape	□ Codeine	□ Latex	□ Penicillin	□_____
□ Anticoagulant Therapy	□ Demerol	□ Local Anesthetics	□ Seafood	□_____
□ Aspirin	□ Iodine	□ Novocain	□ Sulfa	□_____

CURRENT MEDICATIONS

Please Include Prescriptions and Over the Counter Drugs

Name	Dose

□ Continue on back or separate sheet

SURGICAL HISTORY

Type of Surgery	Date

□ Continue on back or separate sheet

FAMILY HISTORY

Please indicate if your Mother, Father, Sibling, Grandparent, Son, or Daughter has any of the following:

□ Arthritis	□ Heart Trouble	□ Mental Disease	□ Sudden Death
□ Cancer	□ High Blood Pressure	□ Sickle Cell Anemia	□_____
□ Diabetes	□ Kidney Disease	□ Stroke	□_____

CONSENT

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance.

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PATIENT INFORMATION

Last Name	First Name	Middle Initial	Social Security Number

Address	City	State	Zip Code

Sex	Marital Status	Date of Birth	Consent to text msg?	Best time to be contacted?
☐ Male ☐ Female	☐ S ☐ M ☐ D ☐ W	/ /	☐ Yes ☐ No	

Home Phone	Work Phone	Mobile	Preferred contact phone
( )	( )	( )	☐ Home ☐ Work ☐ Mobile

Race:
☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ More than one race ☐ Native Hawaiian or Another Pacific Islander ☐ White

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Email Address	Primary Care Physician	Patient's Occupation

RESPONSIBLE PARTY

Last Name	First Name	Middle Initial	Social Security Number

Address	City	State	Zip Code

Home Phone	Work Phone	Mobile	Relationship to Patient
( )	( )	( )	

EMERGENCY

Emergency Contact/Next of Kin	Relationship	Preferred Phone Number
		( )

Address	City	State	Zip Code

PHARMACY

Pharmacy Name	Phone Number	Fax Number
	( )	( )

Address	City	State	Zip Code

INSURANCE

Primary Insurance	Secondary Insurance	Self-Pay ☐YES ☐NO
		Workman Comp? ☐YES ☐NO
Policy Number	Policy Number	Workman Comp Policy Name
Group Number	Group Number	

FINANCIAL AGREEMENT AND INSURANCE ASSIGNMENT

I have authorized treatment by any Jerlin Podiatry, LLC provider and/or any affiliated medical staff member(s). I further authorize release of any and all medical and/or billing information as is necessary for third party reimbursement from my insurance carrier. I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all treatment that the payor determines as noncovered services, as well as, attorney's fees of 33 1/3% and any other related costs of collection should such action become necessary.

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MEDICAL PATIENT ONLY

PLEASE COMPLETE IF YOU HAVE MEDICARE OR MEDICARE COMMERCIAL PLAN

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Jerlin Podiatry, LLC for any services furnished me by their physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare 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 determination of the Medicare carrier.

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