Foot Care of Lebanon
1405 Baddour Pkwy., Suite 104
Lebanon, Tennessee 37087

PATIENT REGISTRATION FORM

(Please fill in every blank, including back of form)

Today's Date: ____________

PATIENT NAME: ______________________________

*****IF MINOR PARENT'S NAME: ______________________________

ADDRESS: ______________________________
____

HOME PHONE: ( ) ______________ **CELL PHONE:** ( ) ______________

DATE OF BIRTH: ______________ **SOCIAL SECURITY #:** ______________

SEX ☐ MALE ☐ FEMALE

RACE
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Caucasian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Other: ______________

ETHNICITY
☐ Hispanic or Latino
☐ Not Hispanic or Latino

PREFERRED LANGUAGE
☐ English
☐ Spanish
☐ Other: ______________

PREFERRED METHOD TO CONTACT YOU
☐ Home Phone okay to leave message
☐ Home Phone NOT okay to leave message
☐ Cell Phone okay to leave message
☐ Cell Phone NOT okay to leave message
☐ Work Phone

EMPLOYMENT STATUS
☐ Employed
☐ Unemployed
☐ Self-Employed
☐ Retired
☐ Disabled

OCCUPATION: ______________ **WORK PHONE:** ( ) ______________

EMPLOYER'S NAME AND ADDRESS: ______________________________
____

MARITAL STATUS
☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

NAME OF SPOUSE: ______________________________

EMERGENCY CONTACT (Someone not living with you)
Name: ______________________ Relationship: ______________________
Address: ______________________ Phone #: ______________________

PCP: ______________________________

Referring Physician: ______________________________

RESPONSIBLE PARTY (Required for all minors)

Name: ______________________ Date of Birth: ______________

Address: ______________________________

Relationship: ______________________ Social Security #: ______________

Home Phone (   ) ______________________ Cell Phone (   ) ______________

PRIMARY INSURANCE INFORMATION

Insurance Carrier: ______________________ Employer: ______________

Subscriber Name: ______________________ Date of Birth: ______________

Social Security #: ______________________ Relationship: ______________

SECONDARY INSURANCE INFORMATION

Insurance Carrier: ______________________ Employer: ______________

Subscriber Name: ______________________ Date of Birth: ______________

Social Security #: ______________________ Relationship: ______________

RELEASE OF INFORMATION

Due to HIPAA regulations we are **NOT** able to release any information about you to anyone, including your family, without your written permission. This means that we **CANNOT** give your spouse your test results or appointment information.

Do you want anyone to be allowed to receive information for you: please circle answer below:

NO **YES,** please list names below

____

____

☐ I wish to receive a copy of the Privacy Policy.

☐ I decline a copy of the Privacy Policy.

By signing below, I am verifying that all the information on this form is truthful and accurate to the best of my knowledge.

X______________________ ______________________

Patient Signature DATE

Patient/Legal Guardian

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AUTHORIZATION FOR TREATMENT AND BILLING

AUTHORIZATION FOR MEDICAL TREATMENT

I authorize the physicians and physician extenders at Foot Care of Lebanon to conduct and direct my medical care. I also authorize Foot Care of Lebanon, directed by my physician, to give medications, perform diagnostic procedures, and provide other care which, in the judgment of my doctor, is required for my best care and treatment.

ASSIGNMENT OF BENEFITS

I direct and authorize payment directly to my physician for all monetary benefits available to me. It is expressly understood and agreed that acceptance by the said hospital, of benefits under this policy, shall in no way operate to release the person responsible for payment of the services referred to herein from his or her obligation to pay for all charges not covered by my insurance policy or excess of said policy limits.

GUARANTEE OF PAYMENT

For value received, the undersigned hereby unconditionally guarantees the prompt payment of all its charges, hereby agreeing to pay all cost and expenses incurred in enforcing this guarantee. In the event the patient or guarantor fails to comply with their obligation herein,each consents to the disclosure of their identity and any other necessary information relating to service rendered to the patient by the attending physician to any collection agency or attorney at law, for the purpose of enforcing the patient's or guarantor's obligation to the health group and the re-disclosure of such information by the collection agency or attorney. Such disclosure or re-disclosure shall not be deemed to be a breach of the patient confidentiality by the health group.

RELEASE OF WRITTEN AND/OR VERBAL INFORMATION FOR BILLING AND UTILIZATION REVIEW PROCESS

I authorize my physician to release written and/or verbal information from my medical record, as necessary, to process my insurance claims and for utilization review when justification for treatment or continued treatment is required.

MEDICARE ASSIGNMENT AND AGREEMENT TO PAY MEDICARE NON-COVERED CHARGES

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician to release to the Social Security Administration and/or its intermediaries and/or carriers any information needed for this or any related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician organization furnishing these services, or authorize the above to submit a claim to Medicare for payment to me. I understand Medicare Participating Physicians have been advised by the Centers for Medicare & Medicaid Services (CMS) that services proviced to Medicare Beneficiaries, which are deteremined by CMS to be unnecessary, will not be paid for by Medicare. The physician may not collect for these services from the patient, unless an Advanced Beneficiary Notification (ABN) has been signed by the patient at the time services were rendered.

By signing below, I am verifying that I have read all of the above statements and agree to each statement.

X____
Patient Signature DATE
Patient/Legal Guardian

X____
Witness DATE

Foot Care of Lebanon

Patient Medication List

Please list ***ALL*** medications that you are taking - prescription and over the counter, vitamins and/or herbal supplements. If they are taken "as needed", please indicate in the directions column.

Name: ______________________________

Drug Allergies: ______________________________

Preferred Pharmacy: ____________________ Phone: ____________________

Medicine	Dose	Directions

Please list all surgeries and major illness: ______________________________

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____

____

____

Reorder from R&M Printing (615) 453-5770

Foot Care of Lebanon
1405 Baddour Pkwy., Suite 104
Lebanon, TN 37087

(615) 453-5440
Toll-Free 1-888-354-5440
Fax 615-453-5441

COMPLIANCE NOTIFICATION

Foot Care of Lebanon is reaching out to its patients to ensure compliance with Federal Code ***47 U.S. Code 227-Restrictions on use of telephone equipment.*** *To summarize, this law details restrictions on the use of fax machine and auto dial equipment with respect to calling a patients cell phone.*
We are asking our current patients to update their registration forms to obtain consent for both cell phone usage as well as contact using email or other demographic information provided.

" Consent to Wireless Telephone call: If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payments for items and services, unless I notify the hospital or office to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic communication from hospital, office, affiliates, contractors, services, clinical providers, attorneys or its agents including collection agencies."
" Consent to email usage: If at anytime I provide my email address at which I may be contacted, unless I notify the hospital or office to the contrary in writing, I give consent to receiving communications regarding billing and payment for services or payment for items at the email address from the hospital, office, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

Thank you for taking the time to provide us with this information

*Your email address:*______________________________

____ *I decline to give out my email or I do not have an email*

*Authorized Signature:*______________________________

*Print name:*______________________________

*Date:*______________________________

Compliance Officer-Emily Neal
Foot Care of Lebanon
100 Physicians Way Suite 210.
Lebanon, TN 37090