Jack Sasiene DPM
PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name _____ _____

Address_____ _____

City, State _____ Zip_____

Telephone (_____)_____

E-mail _____

SS# _____

□ Male □ Female

□ Single □ Married □ Widow □ Divorced

□ American Indian or Alaska Native □ Asian

□ Black or African American □ White

□ Native Hawaiian □ Hispanic Latino □ Other

Date of Birth _____

Occupation _____

Employer _____

Employer Address_____

City, State_____ Zip_____

Work Phone (___)_____

Cell Phone (___)_____

SPOUSE INFORMATION (if applicable)

Name_____

Home Phone (___)_____

Work Phone (___)_____

PHARMACY INFORMATION

Pharmacy Name _____

Address_____

City, State _____ Zip_____

EMERGENCY CONTACT (if other than spouse)

Name_____

Relationship_____

Telephone (____)_____

COMPLETE ONLY IF PATIENT IS UNDER AGE 18

Name_____

Address_____

City, State_____ Zip _____

Telephone (___)_____

SS# _____

Occupation_____

Employer_____

Employer Address_____

City, State_____ Zip_____

Work Phone (___)_____

PHYSICIANS INFORMATION

Primary Physician_____

Office Number (___)_____

Referring Physician_____

Health Insurance Concerns

Please be advised that with the drastic changes to medial Insurance policies, it is more important than ever for you to be aware of your health insurance benefits including co pays, deductions, and percent of the bill you may owe.

We make every effort as a courtesy to our patients and to properly run our office, to check your benefits. However, we are told on the phone that this is not a guarantee of payment. Sometimes we are given incorrect information on your policy. This does create a difficult situation as we are in the middle.

It is important to understand that Dr. Sasiene provides and suggests only treatments that are medically necessary. We understand some treatments may be expensive, but as the patient, you should only agree to a treatment plan you can afford if there is any question as to the coverage, because the patient is ultimately responsible financially.

We are bound by contract with your insurance company to collect any fees they state per your policy, you are responsible for including: co pays, deductible and your percent of procedure fees as applicable. We estimate these based on the information from your insurance plan and prior payments by them. We collect an estimated amount from you at the time of service. Once the claim is processed, you may get a bill/refund based on what they have stated your portion should be.

Thank you for your understanding and assisting us to make your healing less and not more painful.

Patients Signature _____

Date _____

Financial Policy

Welcome to Jack Sasiene DPM Office. We appreciate your confidence and goodwill. To ensure that we have financial stability and can continue to provide medical services to the community and region, the following policies shall be enforced.

Uninsured Patients

All charges are due and payable at time of service. We accept cash, checks and major credit cards. We may reschedule the appointment if payment is not made prior to services rendered.

Patients with Insurance

The physicians will bill insurance plans as a courtesy to their patients if the patient provides the required insurance information before filing deadline and signs an assignment of benefits statement. All information given regarding the ability to pay, third party insurance, employment etc., will be subject to verification.

It is the patient's responsibility to determine whether a referral is required and referral can be requested from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled. If the patient's insurance rejects, denies or covers only a portion of treatment, the patient shall be responsible for immediate payment for the medical service provided. This payment may be requested and is due at the time of service. A pretreatment deposit may be required.

No Show and Cancellation Policy

If the patient fails to cancel his/her procedure/test appointment at least 72 hours in advance, the patient will be responsible for a $50.00 fee which will not be applied to any co pay, deductible or coinsurance.

Delinquent/ Unpaid Account

Prior to providing services, payment of prior outstanding accounts will be requested and should be received. Patients with unpaid delinquent accounts or accounts which have been written off to bad debt may be denied treatment if not medically urgent. Accounts which cannot be collected by the physician after normal in-house collection procedures may be referred to a collection agency, magistrate, or attorney for further collection action in accordance with the physicians established guidelines. Changes shown by statements are to be correct and responsible unless protested in writing within (30) thirty days of billing.

Refunds

Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patients refunds will not be processed until all active or past due accounts are paid in full.

Third Party Litigation

Our physician will not become involved in disputes arising from third party claims (i.e. automobile accidents, liability claims, etc.) with the exception of verified Worker's Compensation claims.

Insurance/Disability forms

There will be a $25.00 handling fee to cover the administrative fee for writing a letter or filling out claims forms, such as insurance forms and disability forms (except Medicare patients). The fee is due once the form is completed, and the patient will be directly responsible for this fee.

Returned Checks

Checks returned to Jack Sasiene DPM for insufficient funds, closed account, stopped payment, or for any other reason will be subject to $50.00 fee.

Medial Record

A reasonable fee of $25.00 shall be charged for the first twenty pages and $0.15 per page for every copy thereafter. Requests will be completed within ten (10) business days.

Acknowledgement of Receipt of Notice of Privacy Policy

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose and understand the notice).

Patients name PRINTED_____

Patients Signature_____

Date_____

Is your treatment today due to:

☐ **A work related injury** **_____ Injury Date**

Do you have written authorization from your employer and comp carrier to be treated? ☐ Yes ☐No

☐ **A motor vehicle accident** **_____Accident Date**

☐ **An accident/liability case** **_____Accident Date**

Whom may we thank for sending you to our office?

☐ **Doctor_____**	**Verizon Yellow Pages**
☐ **Patient_____**	**The Yellow Book**
☐ **Newspaper_____**	**Insurance Provider List**
☐ **Other_____**	**Passed by Location**

I hereby authorize the release of any medical information pertaining to my treatment or information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignments. This authorization will remain valid until revoked by me in writing. I understand that I am legally responsible for all charges whether or not reimbursed by insurance company. I also authorize Dr. Jack Sasiene DPM to electronically access my prescription records in regards to my care

Signature_____ **Date_____**

Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Jack Sasiene DPM PA for any services furnished me by the listed provider/supplier. 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 to 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 other approved claim forms or electronically submitted claims, my signature authorizes the releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider of 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.

Patients name PRINTED_____ **Provider Information:**

Patients Signature_____ **Jack Sasiene DPM**

Date_____ **3200 Palmer Highway**

Patients Medicare No._____ Texas City, TX 77590

Patient Name: _____ **Date**: _____

MEDICAL HISTORY INFORMATION

1. **Explain your foot/ankle problem** ☐ Right ☐ Left _____
_____
2. **Describe the pain/discomfort:** ☐ Burning ☐ Numbness ☐ Sharp ☐ Other_____
3. **When did the pain/discomfort begin?** _____
4. **What makes the pain/discomfort better?** _____
5. **What makes the pain/discomfort worse?** _____
6. **List all medications/herbs/vitamins**: ☐ None _____
_____
7. **List all allergies to drugs, food and environment and reaction associated**: ☐ None

☐ **Penicillin** _____ ☐ **Aspirin** _____ ☐ **Narcotic Agent/Codeine** _____
☐ **Anesthesia** _____ ☐ **Shellfish** _____ ☐ **Sulfa Drugs** _____
☐ **Nickel/Metal** _____ ☐ **IVP Contrast Dye**_____ ☐ **Other**_____

8. **PAST/CURRENT MEDICAL AND FAMILY HISTORY**

Condition	Self	Family (Please provide who)		Self	Family (Please provide who)
Anemia	☐	☐_____	Kidney Disease	☐	☐_____
Arthritis	☐	☐_____	Liver Disease	☐	☐_____
Asthma	☐	☐_____	Mental Retardation	☐	☐_____
Bleeding Disorders	☐	☐_____	Mitral Valve Prolapse	☐	☐_____
Cancer	☐	☐_____	Multiple Sclerosis	☐	☐_____
Circulation Problems	☐	☐_____	Nail Disorders	☐	☐_____
Diabetes Avg Glucose _____	☐	☐_____	Nerve Disorders	☐	☐_____
How long have you been diabetic? _____			Obesity	☐	☐_____
Epilepsy	☐	☐_____	Phlebitis	☐	☐_____
Gout	☐	☐_____	Rheumatic Fever	☐	☐_____
Heart Disease	☐	☐_____	STD	☐	☐_____
Hepatitis	☐	☐_____	Skin Problems	☐	☐_____
High Blood Pressure	☐	☐_____	Stomach/Intest Problems	☐	☐_____
High Cholesterol	☐	☐_____	Stroke	☐	☐_____
HIV/AIDS	☐	☐_____	Thyroid Disorders	☐	☐_____
Major Injury/Trauma	☐	☐_____	Varicose Veins	☐	☐_____

9. **SURGICAL HISTORY: Have you had surgery?** ☐ Yes **If Yes, List them Below** ☐ No
_____

10. SOCIAL HISTORY:	YES	NO	If YES, How Often?		YES	NO
Tobacco Use	☐	☐	_____	Caffeine Use	☐	☐
Alcohol Use	☐	☐	_____	Drug Use	☐	☐

11. **Do you Exercise?** ☐ No ☐ Yes **If Yes, Explain:**_____
12. **Occupation:** _____ **Is your problem work related?** _____
13. **Are you currently pregnant?** ☐ No ☐ Yes **If Yes, When are you due?** _____
14. **Height:** _____ **Weight:** _____ **Shoe Size:** _____

BY SIGNING I CONSENT THAT ALL THE INFORMATION PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE

PATIENT NAME PRINTED_____ **SIGNATURE**_____

REVIEW OF SYSTEMS:

Please check any of the following that you are currently experiencing or have recently experienced:

Constitutional

____ Chills **____ Fatigue** **___Fever**

____Weakness **____Weight loss**

Head

___Dizziness **___Fainting** **____Headaches**

Respiratory

___Asthma **___Short of breath** **___Wheezing**

___COPD **___Bronchitis** **___TB**

Cardiovascular

___Hair loss on Legs **___Leg or Foot Ulcers** **___Vascular Graft/Stents**

___Heart Murmur **___Cramps in legs or feet** **___Replacement heart valve**

___Cold Feet **___History of heart attack**

Gastrointestinal

___Liver disease **___Hepatitis** **___Antacid Use**

___Nausea **___Excessive thirst** **___Gall Bladder Disease**

Musculoskeletal

___Joint Stiffness **___Lower Back Pain** **___Joint Implants**

___Restricted Motion

Psychiatric

___Depression **___Anxiety** **___Memory Loss**

Skin

___Eczema **___Dryness** **___Athletes Foot**

___Keloid Scars **___Itching** **___Ugly Toe Nails**

Neurological

___Burning **___Fainting** **___Strokes**

___Unsteady Balance **___Numbness** **___Tingling**

Endocrine

___Sweats **___Thyroid**

Hematologic/Lymph

___Bruises Easily **___Slow Healing Cuts** **___Bleeds Easily**

___Recent Chemo/Radiation **___Blood Clots**

Signature X_____