

**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.

Patient/Legal Guardian 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).

Patient/Legal Guardian name PRINTED _____

Patient/Legal Guardian 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

How did you hear about our office?

Doctor _____

Facebook

Family/Friend

Google/Internet

Insurance Website

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

Explain your foot/ankle problem Right Left _____

Describe the pain/discomfort: Burning Numbness Sharp Other _____

When did the pain/discomfort begin? _____

What makes the pain/discomfort better? _____

What makes the pain/discomfort worse? _____

List all medications/herbs/vitamins: None _____

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 _____

PAST/CURRENT MEDICAL AND FAMILY HISTORY

Check any that apply	Self	Family (Please provide who)	Self	Family (Please provide who)
Anemia	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Asthma	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Cancer	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Diabetes:	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Avg Glucose _____ How long? _____				
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Gout	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Hepatitis Type _____	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Major Injury/Trauma	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Nail Disorders	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Nerve Disorders	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Obesity	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
STD	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Skin Problems	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Stomach/Intest Problems	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Stroke	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> _____

SURGICAL HISTORY: Have you had surgery? Yes No If Yes, List them Below No

SOCIAL HISTORY:	YES	NO	If YES, How Often/Long	Caffeine Use	YES	NO
Current/Prior Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	_____	Caffeine Use	<input type="checkbox"/>	<input type="checkbox"/>
Current/Prior Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	_____	Drug Use	<input type="checkbox"/>	<input type="checkbox"/>

Do you Exercise? No Yes If Yes, Explain: _____

Occupation: _____ Is your problem work related? _____

Are you currently pregnant? No Yes If Yes, When are you due? _____

Height: _____ Weight: _____ Shoe Size: _____

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

PATIENT/LEGAL GUARDIAN 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 _____