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 (____)_____

PARENT INFORMATION

COMPLETE 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 physician's 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. Patient's 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 claim's 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.

Medical 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_____

FILL OUT ALL AREAS THAT APPLY

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 _____**

☐ **Family/Friend**

☐ **Insurance Website**

☐ **Facebook**

☐ **Google/Internet**

Authorization to Release Medical Information:

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 reimbursed by insurance company. I also authorize Dr. Jack Sasiene DPM to electronically access my prescription records regarding 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_____

Patients Signature_____

Date_____

Provider Information:

Jack Sasiene DPM

3200 Palmer Highway

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? _____

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?** _____

MEDICATIONS: ☐ **None**

_____

_____

ALLERGIES: ☐ **None** ☐ Penicillin ☐ Aspirin ☐ Shellfish ☐ Narcotic Agent/Codeine ☐ Anesthesia ☐ Sulfa Drugs ☐ Nickel/Metal ☐ IVP Contrast Dye ☐ Other_____

SOCIAL HISTORY:

Tobacco Use ____ Yes/No How long ? _____ **Alcohol Use** Yes/ No Frequency ? _____ **Drug Use** Yes/No

MEDICAL HISTORY

___Anemia	___Hepatitis Type ____	___Nail Disorders
___Arthritis	___High Blood Pressure	___Nerve Disorders
___Asthma	___High Cholesterol	___Obesity
___Bleeding Disorders	___HIV/AIDS	___Phlebitis
___Cancer	___Major Injury/Trauma	___Skin Problems
___Circulation Problems	___Kidney Disease	___Thyroid Disorders
___Diabetes: Glucose _____How long? _____	___Liver Disease	___Stroke
	___Mental Retardation	___Stomach/Intest Problem
___Gout	___Mitral Valve Prolapse	___Varicose Veins
___Heart Disease	___Multiple Sclerosis	

SURGICAL HISTORY:

Have you had surgery? ☐ **Yes** If Yes, List them Below ☐ **No**

_____

_____

FAMILY HISTORY:

	List who		List who		List who
___ Anemia	_____	___ Hypertension	_____	___ Nail Disorders	_____
___ Arthritis	_____	___ HIV/AIDS	_____	___ Nerve Disorders	_____
___ Asthma	_____	___ Major Injury	_____	___ Obesity	_____
___ Cancer	_____	___ Kidney Disease	_____	___ Phlebitis	_____
___ Diabetes	_____	___ Liver Disease	_____	___ Skin issues	_____
___ Gout	_____	___ Mental Retardation	_____	___ Thyroid	_____
___ Heart Disease	_____	___ Mitral Valve Prolaspe	_____	___ Stroke	_____
___ Hepatitis	_____	___ Multiple Sclerosis	_____	___ GERD	_____
				___Varicose Veins	_____

PATIENT/LEGAL GUARDIAN NAME 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

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 SIGNATURE _____