BRIAN CRISPELL D.P.M LLC

1078 W BALTIMORE PIKE

RIDDLE HCC 1 SUITE 209

MEDIA, PA 19063

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| PATIENT’S LAST NAME | FIRST NAME | | | MIDDLE  INITIAL | | SOCIAL SECURITY NUMBER | | BIRTHDATE | | | AGE |
| RESIDENCE ADDRESS | | CITY | | | STATE | | ZIP | | | HOME PHONE NUMBER | |
| CELL PHONE NUMBER (may we use text messages to notify you of future appts? YES/NO  EMAIL ADDRESS (may we use email to notify you for future appts? YES/NO) | | | | | | | | | | | |
| SEX M F | | | OCCUPATION (if retired state from what) | | | RACE/ETHNICITY(optional) | | | Preferred Language (if other than English) | | |
| NAME OF POLICY HOLDER  (if different from patitent) | | | POLICY HOLDER SOCIAL SECURITY # | | | POLICY HOLDER BIRTH DATE | | | RELATIONSHIP TO PATIENT | | |
| POLICY HOLDER ADDRESS (if different from patient) | | | CITY | | | STATE | | | ZIP | | |
| POLICYHOLDER/EMPLOYER | | | | EMPLOYER ADDRESS | | | | EMPLOYER PHONE NUMBER | | | |
| STUDENT  Full Time Part Time | | | | | | SCHOOL NAME AND ADDRESS | | | | | |
| SPOUSE EMPLOYER (if spouse holds policy) | | | | EMPLOYER ADDRESS | | | | EMPLOYER PHONE NUMBER | | | |
| EMERGENCY CONTACT PERSON | | | ADDRESS | | | PHONE NUMBER OF CONTACT PERSON | | | RELATIONSHIP TO PATIENT | | |
| HAVE YOU HAD PREVIOUS TREATMENT BY A PODIATRIST FOR THIS CONDITION?  YES NO | | | | WHEN? | | | | DOCTOR’S NAME | | | |

PLEASE BE ADVISED THAT FOR ANY PORTION OF YOUR CHARGES THAT YOUR INSURANCE COMPANY DEEMS YOUR RESPONSIBILITY, YOU WILL BE ALLOTTED 30 DAYS TO MAKE PAYMENT IN FULL. AFTER 30 DAYS, A $5.00 DELINQUENCY FEE WILL ACRUE PER MONTH. AFTER 90 DAYS, IF PAYMENT HAS STILL NOT BEEN MADE, YOUR ACCOUNT WILL BE FORWARDED TO A COLLECTION AGENCY AND ALL ADDITIONAL FEES INVOLVED WITH THE COLLECTION PROCESS WILL BE ADDED TO YOUR RESPONSIBILITY. I UNDERSTAND THAT ANY KNOWN CHARGES (INCLUDING COPAYS, CO-INSURANCES AND/OR DEDUCTIBLES) ARE MY RESPONSIBILITY AND ARE PAYABLE AT THE TIME OF MY APPOINTMENT. A FEE OF $10.00 WILL BE ASSESSED IF I DO NOT MAKE PAYMENT AT THE TIME OF SERVICE. I UNDERSTAND THAT I WILL BE RESPONSIBLE TO INFORM DR. CRISPELL'S OFFICE IF I SEE ANOTHER PODIATRIST WITHIN THE TIME ALLOTTED BY MY INSURANCE COMPANY. I FURTHER UNDERSTAND THAT IF MY INSURANCE COVERAGE CHANGES, I WILL NOTIFY DR. CRISPELL'S OFFICE WITH THE CORRECT INFORMATION. I HAVE READ AND UNDERSTAND THE ABOVE POLICY AND AGREE TO ADHERE TO ITS GUIDELINES.

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PATIENT SIGNATURE DATE

1. ASSIGNMENT AND RELEASE:

I, THE UNDERSIGNED, HAVE INSURANCE AND ASSIGN THE PAYMENT DIRECTLY TO BRIAN CRISPELL D.P.M LLC FOR ALL INSURANCE/MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY THE INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS.

PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. MEDICARE AUTHORIZATION:

I REQUEST THAT PAYMENTS OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO BRIAN CRISPELL D.P.M FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN, 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 PAYABLE FOR 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 ON ANY CLAIMS, MY SIGNATURE AUTHORIZES RELEASE OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. CERTAIN SERVICES MAY NOT BE COVERED OR FULLY REIMBURSED BY MEDICARE. I AUTHORIZE THE DOCTOR TO PROCEED WITH THE SERVICES WHETHER OR NOT COVERED BY MEDICARE. IF MEDICARE DENIES PAYMENT, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT. IN MEDICARE ASSIGNED AND COVERED CASES, THE PHYSICIAN AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE. THE PATIENT IN THAT CASE IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE, AND NON-COVERED SERVICES.

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF BENEFICIARY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POLICY #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. WORKERS COMPENSATION:

I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT IN THE EVENT THAT MY CLAIM FOR WORKERS COMPENSATION BENEFITS IS DENIED.

PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. PEDIATRIC ASSIGNMENT AND RELEASE:

I CERTIFY THAT MY MINOR/CHILD IS COVERED BY THE INSURANCE ON THE FRONT PAGE AND ASSIGN IT DIRECTLY TO BRIAN CRISPELL D.P.M LLC ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL OF MY INSURANCE SUBMISSIONS.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. MEDICAL ASSISTANCE:

MY SIGNATURE CERTIFIES THAT I RECEIVED THE SERVICES SUBMITTED. I UNDERSTAND THAT PAYMENT FOR THIS SERVICE OR ITEM WILL BE FROM FEDERAL OR STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF MATERIAL MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS.

PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_