BRIAN CRISPELL D.P.M LLC
100 Granite Drive STE 4
MEDIA, PA 19063

PATIENT'S LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER	BIRTHDATE	AGE

RESIDENCE ADDRESS	CITY	STATE	ZIP	HOME PHONE NUMBER

OUR COMPUTER SYSTEM USES AUTOMATED APPOINTMENT REMINDERS VIA TEXT MESSAGE, PHONE CALL, AND/OR EMAIL WOULD YOU LIKE TO BE ENROLLED INTO THIS SERVICE? YES / NO

EMAIL:

CELL:

SEX M F	OCCUPATION	RACE/ETHNICITY (optional)	PHARMACY AND PHONE #

NAME OF POLICY HOLDER (if different from patient)	RELATIONSHIP TO PATIENT	POLICY HOLDER BIRTH DATE	PHARMACY ADDRESS

POLICY HOLDER ADDRESS (if different from patient)	CITY	STATE	ZIP

POLICY HOLDER EMPLOYER	EMPLOYER PHONE NUMBER	

SPOUSE EMPLOYER (if spouse holds policy)	SPOUSE'S EMPLOYER PHONE NUMBER	

EMERGENCY CONTACT PERSON	PHONE NUMBER OF CONTACT PERSON	RELATIONSHIP TO PATIENT	STUDENT? FULL TIME OR PART TIME

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.

_____

PATIENT SIGNATURE or (Parent/Guardian if under 18) 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 (Parent/guardian if under 18):_____ 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 (parent/guardian if under 18):_____ 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 (parent/guardian if under 18): _____ DATE: _____