The Lower Extremity Specialty Alliance

Today's Date: _____

Patient Name: First:_____ **M.I.** _____**Last:** _____

Date of Birth:_____ **Age:** _____**Sex: F M**

Marital Status: _____

Social Security Number: _____

Home Address: _____

City, State, Zip: _____

Phone Number: _____

Email Address: _____

Preferred Method of Contact: E-mail_____ **Call**__ **Text**__

Patient Portal Access: Y N

Primary Care Physician: _____

Preferred Pharmacy(Name/Zip/City): _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Emergency Contact Relation: _____

Insurance Holders Name: _____

Insurance Holders DOB: _____

Patient Agreement and Authorization

Please indicate that you have read and agree to each of the following terms by initialing on the preceding blank space.

_____Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read, or been orered a copy, and understand the notice (Available upon request)

_____Acknowledgement of Financial Responsibility

I acknowledge that regardless of my insurance benefits, if any, that I am responsible for fees and services rendered. In the event of non-payment, I understand that I am responsible for collection, attorney and/or court costs.

All co-pays must be paid at time of service. This arrangement is part of your contract with your insurance company. Although our office accepts most insurance carriers, it is ultimately your responsibility to understand your network participation with your individual plan. You will be sent up to three notices for your balance. Upon the third notice, your account may be forwarded to our collection agency. At this time, you will not be able to receive any care from our o:ice until this is paid in full with them.

I authorize The Lower Extremity Specialty Alliance to bill my insurance and am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees at the time of service.

_____Authorization of Release of Information

I hereby authorize release of medical information to my insurance carrier or requested healthcare providers for continuity of care. I understand that it is my responsibility to notify the office immediately if there is a change in my insurance information. It is my responsibility to maintain coordination of benefits information with insurance. I acknowledge that by consenting I release my past medical history, medication history and ability for this office to obtain medical records to assist in the treatment of my condition(s).

_____Acknowledgement of Treatment

I request and authorize Dr. David Bishop and or staff and resident physicians to perform general procedures as may be deemed necessary in the diagnosis and or treatment of my foot and or ankle condition. Such as: Phenol Matrixectomy, Incision and Drainage and Verruca, Radiograph(s).

No Show Policy: *If 3 or more "No Shows" for appointments, the office may discharge from our practice.*

I authorize the release of my information to the following

Name: _____Relationship to the Patient: _____

Name: _____ Relationship to the Patient: _____

I certify to the best of my knowledge that the information provided here is true and accurate.

_____

Signature **Parent/Authorized Representative** **Date**