WELCOME TO OUR OFFICE

Date:________________ Date of Birth: ______/_______/_______ Age:_______

Patient`sName:____SS#________________________

Local Address:________________________________City____________________State_____Zip Code___________

Home Phone: __________________Cell Phone:____________________ Business Phone________________________

Northern Address:______________________________City___________________State______Zip Code___________

Northern Phone Number:____

Marital Status:__________ Spouse Name:____

Contact in Case of Emergency: ____________________________________Phone Number_____________________

Employer____Occupation________________________________

Primary Insurance_______________________________________Secondary_________________________________

HOW DID YOU LEARN OF OUR OFFICE? (Please give names)

Friend_____________________________________Doctor____
Yellow Pages____________Newspaper__________Internet______________Other____________________________

MEDICAL INFORMATION

Family Physician: ______________________________ Last visit to Family Physician:________/_______/_________
What is your foot problem today____
____

Please check any of the following conditions you have or have had:

Diabetes	____	Rheumatoid Arthritis	____	Asthma	____
Prolong Bleeding	____	HIV + AIDS	____	Hepatitis	____
Stroke	____	Heart Attack	____	Cancer	____
High Blood Pressure	____	COPD	____	Digestive Tract Ulcer	____
Arthritis	____	Thyroid Disease	____	Back Pain	____
Seizure	____	Blood Clots	____	Liver Problems	____
Heart Problems	____	Kidney Problems	____	Lung Problems	____

ALLERGIES:____
Current Medications: ____

Please give the Receptionist your INSURANCE CARDS for photocopy.
THANK YOU.

THIS IS OUR OFFICE FINANCIAL POLICY-

PLEASE SIGN BELOW

In our office we are committed to providing you with the best possible care. If you have Medical Insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve goals, we need your assistance, and your understanding of our payment policy.
Unless INSURANCE ARRANGEMENTS have been approved in advance by our staff, payment for services is due at the time services are rendered. We accept payment in the form of cash, check, Visa or Mastercard. We will be happy to help you process your insurance claim at each visit.
Returned checks and balances older than 30 days are subject to additional collection fees and interest of 1.5% per month. We will gladly discuss your proposed treatment an answer any questions relating to your insurance.
You must realize, however, that:

1. **INSURANCE IS A CONTRACT; BETWEEN YOU AND YOUR INSURANCE COMPANY.**

2. Our fees generally fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R.(Usual Customary and Reasonable fees for this region). Thus, our fees are considered Usual, Customary and Reasonable by most companies. This does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard of fees and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily refuse to cover certain services. We have no control over this.

4. **MEDICARE PATIENTS**. We would like you to understand that taking assignment means that **YOU ARE RESPONSIBLE FOR THE YEARLY DEDUCTIBLE OF $124.00 and for the 20% (co-insurance)** of what MEDICARE allows. You are also responsible for services that your CO-INSURANCE doesn`t cover. If your co-insurance doesn`t pay this amount, you are responsible for it.

5. I hereby give Dr. Gensemer and /or Dr. Sherman permission to take photographs, for a visual record of my foot condition.

Unlike some offices, the filing of insurance claims is a courtesy that we have always extended to our patients. <u>However, all charges are your responsibility, not your Insurance Company`s. We will make our best effort to collect from them, but if, despite our best efforts, we are not successful, you are responsible for the unpaid balance.</u>

We realize that temporary financial problems may affect timely payment of your account. We don`t want any financial problems to get in the way of our good relationship with you. If such problems do arise we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We really are here to help you.

X____

Your Signature –I have read and understand the above

PLEASE SIGN THE INSURANCE AND/OR MEDICARE ASSIGNMENT BELOW:

I authorize payment of Medical Benefits be made on my behalf to Dr. Gensemer and/or Dr. Sherman, for any services furnished to me. I authorize the release of any medical information held by Dr. Gensemer and/or Dr. Sherman to the health care financing administration and its agents, to process my claims.

X____

Your Signature- I have read and understand the above