

(812) 448-9290

FAX (812) 448-9296

PATIENT INFORMATION

Date _____

Name (First) _____ (MI) _____ (Last) _____

Soc.Sec # _____ Birthdate _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Sex M F Single Married Divorced Widowed Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

In case of emergency who should be contacted? _____

Phone _____

Person responsible for account _____

Relationship to patient _____ Birthdate _____ Soc.Sec# _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible party employed by _____ Occupation _____

Business Phone _____ Business Address _____

Whom may we thank for referring you? _____

Where did you hear about us? (Check all that apply)

- Brazil Times Ad Radio
- Tribune Star Ad Friend/family member
- Wabash Valley Extra other _____

PRIMARY INSURANCE -

SECONDARY INSURANCE -

ADDITIONAL INSURANCE -

Name of Doctor who follows your diabetes: _____

Date of last visit with this diabetes Doctor: _____

How often do you check your blood sugar at home? _____

Blood sugar this morning? _____ Last HgA1C (3 month test) _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE CLAY COUNTY PODIATRY, LLC and/or RUSSELL HARMS D.P.M. to release information requested by my insurance carrier and/or Workers Compensation carrier. Additionally, I authorize CLAY COUNTY PODIATRY, LLC and/or RUSSELL HARMS D.P.M. to release information to any hospital or physician I may be referred to by this health care provider.

Date _____

Signature _____

Relationship to Patient _____

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE assignment and payment directly to RUSSELL HARMS D.P.M. of any major medical benefits and/or Medicare due me. I understand that insurance may not and that Medicare does not pay one hundred percent (100%) of the medical charges.

I HEREBY ACKNOWLEDGE and agree to pay any and all charges that exceed or that are not covered by insurance and/or Medicare, including any deductible, I also acknowledge that I am responsible for reasonable interest, collection fees, attorney fees for the greater of a) forty percent (40%) or b) \$300.00 of the outstanding balance, and/or court costs incurred in connection with any attempt to collect amounts I may owe.

Date _____

Signature _____

CONSENT FOR TREATMENT

I hereby request and voluntary consent to such office care, including routine diagnostic procedures and medical treatment as may be deemed necessary by RUSSELL HARMS, DPM and/or his designees.

Date _____

Signature _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have been provided a copy of CLAY COUNTY PODIATRY, LLC Notice of Privacy Practices.

Date _____

Signature _____

OFFICE USE ONLY

Date acknowledgment received: _____

-OR-

Reason acknowledgment was not obtained:
