REGISTRATION FORM

PATIENT INFORMATION:

Current Date:

Patient Balance:

Patient DOB:

Patient Gender:

Patient Age:

Patient Last Name:

Patient First Name:

Patient Address:

Patient Email:

Patient Cell Phone:

Primary Insurance Payer:

Primary Insurance Policy:

Primary Insurance Plan:

Secondary Insurance Payer:

Secondary Insurance Policy:

Secondary Insurance Plan:

Allergies:

I hereby authorize the release of medical information to insurance carriers concerning my illness and treatment and I hereby assign the doctor all payments for Medical Services rendered to my dependent. I understand that I am responsible for any amount not covered by insurance. I also give Medical Consent to Dr. Imaze Marian Davis for treatment as well as consent that my medication list be imported electronically from my pharmacy. I give permission to the office to release my health information to my primary care doctor and /or doctors participating in my care.

X ______________________________

Signature

IF THE INFORMATION ABOVE IS INCORRECT PLEASE FILL OUT CORRECT INFORMATION BELOW

PRIMARY CARE DOCTOR:

REFERRING DOCTOR:

SS#: DOB: EMAIL:

IN CASE OF AN EMERGENCY

EMERGENCY CONTACT NAME:

RELATIONSHIP:____________________________ PHONE #:

The above information is true to the best of my knowledge.

x ______________________________ Date:

Signature

Acceptance of Insurance Assignment and Financial Policies

I hereby authorize MARIAN DAVIS DPM PA and its agents to furnish my insurance companies with all necessary information concerning diagnosis and treatment for myself or dependents under compliance of the Health Insurance Portability and Privacy Act of 1996 (HIPAA).

I assign the medical and/or surgical benefits that my dependents and I are entitled to under my health insurance plan to [MARIAN DAVIS DPM PA] and treating physicians.

An estimate will be provided before any services are rendered.

I agree to pay all balances accrued with [MARIAN DAVIS DPM PA] and my treating physicians for services rendered. Cash, personal checks, cashier's checks, money orders, VISA, MasterCard, and Discover are accepted. Other payment agreements set forth by my insurance plan may restrict or limit the ability of [MARIAN DAVIS DPM PA] to collect payment in full.

I understand I am responsible for all co-payments, deductibles and coinsurance. Co-payments must be paid prior to services being rendered. If I do not know the exact co payment or outstanding deductible amount for the current calendar year, then I will pay a minimum of $60.00 prior to receiving care.

I understand some medical/surgical and/or durable medical equipment services will require a pre-paid deposit. All deposits will be applied to any outstanding charges for those services rendered. Any excess funds remaining after receiving insurance remittance will be refunded promptly.

MARIAN DAVIS DPM PA does not generally arrange payment plans. In situations of extreme financial hardship, discuss your situation with the treating physician and/or the office manager and the office would decide if a payment plan will be offered to you.

I understand that I am responsible for any outstanding balance remaining after insurance remittance has been received. A collection fee of 5% will be applied to outstanding balances past 90 days. Any balance not paid after 150 days may be referred to an attorney for collection. All legal and collection fees will be the guarantor's responsibility.

In the case of divorced parents, payment is expected from the person signing this document and will be considered the guarantor for all payments for any services provided. [MARIAN DAVIS DPM PA] will not recognize any divorce decrees regarding reimbursement for medical services for any minor child of divorced parents.
*** (College students with parents insurance, please initial below)***

College students with health insurance under their parent's name will not be treated by any physician from [MARIAN DAVIS DPM PA] without written permission from parent or guardian. Original signature or fax

is allowable. The student being treated gives permission to [MARIAN DAVIS DPM PA] to contact parents regarding his or her health conditions per HIPAA requirements. Parents agree to be responsible for all charges unless other arrangements are made in advance.

Assignment of Benefits and Release of Medical and Plan Documents

I , have insurance and/or employee health care benefits coverage with [Primary Insurance Payer] and hereby assign and convey directly to Marian Davis, DPM, PA all medical benefits and/or insurance reimbursement otherwise payable to me for services rendered from Marian Davis, DPM, PA. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within 90 days from the date of an insurance payment and/or denial. If outside collections are necessary, I will be responsible for all collection and legal fees.

I hereby authorize the doctor to release all medical information necessary to process this claim within HIPAA guidelines. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to Marian Davis, DPM, PA any plan documents, insurance policy and settlement information in order to claim such medical benefits, reimbursement or applicable release. Requests for such information must be submitted in writing. I authorize the use of my signature on all my insurance or employee health benefit claim submissions. I have received the practices HIPAA guidelines and a signed receipt of these guidelines is on file in my medical record.
I agree to cooperate with the staff of Marian Davis, DPM, PA in their pursuit of reimbursement from my insurers and/or employee health care plan, including, if necessary, bringing suit with Marian Davis DPM, PA] against insurers and employee health care plan. In this situation, I understand that the suit would be in my name but at the expense or Martian Davis, DPM, PA.
This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original. I have read and fully understood this agreement.
I hereby authorize the release of medical information to insurance carriers concerning my illness and Treatment and I hereby assign the doctor all payments for Medical Services rendered to my dependent.
I understand that I am responsible for any amount not covered by insurance. I also give Medical Consent to Dr. Imaze Marian Davis for treatment as well as consent that my medical database be retrieved from my pharmacy and/or other treating Physicians.

Insured/Guardian: X ______________________________ Date:
Signature

Consent for Treatment

PERIPHERAL VASCULAR DISEASE/DIABETIC PATIENT

Date of Service:

Patient Name:

Date of Birth:

I understand that I have poor circulation and this is a condition that may/will get worse. I know that I have a risk of disease or complications because I have poor circulation, even with professional care and treatment.

I understand that I have the following treatment options:

___x_____ No treatment
___x_____Special/Wider shoes
___x_____ Padding
___x_____ Soaks
___x_____ Periodic treatment to make me more comfortable
___x_____ Antibiotics and/or other medications
___x_____ Limit my walking/weight-bearing time
___x_____ Change in occupation
___x_____ Surgery

Consent for Treatment

I understand that with any treatment of my condition, including surgery, the following risks are present:

____x____ Infection
____x____ Delayed healing
____x____ Wound deterioration or breakdown
____x____ Additional danger of artery/vein clotting (blood clot)
____x____ Loss of toe, foot, limb, or life
____x____ Drug reaction

These risks are present in all operations/treatment. However, I understand that my poor circulation increases my risk for complications. If I have one or more of these complications, I UNDERSTAND THAT MY FUTURE CARE AND TREATMENT MAY BE MORE DIFFICULT AND THE OUTCOME MORE UNCERTAIN.

NON-TREATMENT OF MY FOOT PROBLEMS also presents serious risks to me. My podiatrist has advised me to see a vascular surgeon or other medical specialist, I UNDERSTAND AND ACKNOWLEDGE MY PODIATRIST (MARIAN DAVIS DPM) WILL TREAT ONLY MY FOOT (and ankle) CONDITIONS AND WILL NOT TREAT DIRECTLY MY SYSTEMIC CONDITIONS (peripheral vascular disease /diabetes).

My podiatrist has explained the above information and the alternatives/material risks to me, I understand this explanation, and I authorize my podiatrist to treat my foot condition(s).

X ______________________________ Date:
Signature

Marian Davis, DPM, PA

Consent for Care, Treatment and Payment

Date:

Patient DOB:

I, for myself or for_______, if I am signing as a Personal Representative, consent to enter into a Patient Relationship with my Physicians office. I understand that my provider and associates (physicians and medical assistants) may also terminate the relationship with proper written notice to me. I agree that you may release information regarding my treatments and services provided to me to third party payers for billing purposes, unless such services are paid for in full out of pocket. I understand that such treatment services may include but not limited to:

- Nails and Skin care - Nails and Skin biopsy
- Nails and Skin biopsy PCR - Wound PCR
- MLS Laser Therapy - EPAT Shockwave
- ABI Arterial Study - Clarifi imaging system
- Sanuwave Ultramist treatment - Wound Care
- Surgical debridement of wound, skin, nails - Radiological x-rays
- Durable medical supply (walking boots, surgical shoes, orthotics, braces, pads, taping, compression garments)
- Over the counter medication and products (Skin, nail, joint and neuropathy)
- Regenerative medicine products/injections hylaronic acid, platelet rich plasma (PRP)
- Surgical suite, set up and supplies used for in office surgery including Minimal incisions surgical (MIS) procedures such as: MIS bunions, hammertoes, soft tissue procedures, osteotomies (Bone procedures), tenotomies (tendon procedures).

The services and products may or may not be fully covered by my insurance and therefore agree to be responsible for payment of such items offered in the office.

I also understand and agree that the office may use my information for its internal and confidential healthcare operations.

Name: X ______________________________ Date:
Signature

Forms for Medicare Beneficiaries

Notice to Medicare Beneficiaries about Coverage for Foot Care and Services

Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits. When you receive foot care services and items that are not covered Medicare benefits, you must pay for them personally or through any other insurance that you may have.

The purpose of this advance notice is to help you make an informed choice about whether or not you want to receive these foot care services or items, knowing that you will have to pay for them yourself. We do not send claims to Medicare for foot care services or items that are excluded from Medicare coverage.

Before you make a decision, you should read this entire notice carefully.

- The Medicare program does not cover most routine foot care and flat foot care. The Medicare law clearly excludes coverage for services in connection with the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care. The Medicare law clearly excludes coverage for services in connection with treatment of flat foot conditions and the prescription of supportive devices thereof or with the treatment of subluxations of the foot. Providers may not be required to submit Medicare claims for such services.

NOTE: A narrow exception permits coverage of some foot care services when certain conditions result in severe circulatory problems or areas of diminished sensation.

- The Medicare program does not cover most orthopedic shoes or other foot support (orthotics). The Medicare law clearly excludes coverage for services in connection with orthopedic shoes or other supportive devices for the feet.

NOTE: A narrow exception permits coverage of special shoes and inserts for certain patients with diabetes.

This means that Medicare will not pay for most routine foot care, flat foot care, orthopedic shoes, or orthotics, because they are not Medicare covered benefits. Payment for these excluded foot care services and items is your responsibility.

If you have any additional questions concerning Medicare coverage for foot care services or items, you can contact Medicare at 1-800-MEDICARE (1-800-633-4227).

This notice is published by: American Podiatric Medical Association (APMA), P.O. Box 9312 Georgetown Road, Bethesda, MD 20814-1621. The Centers for Medicare & Medicaid Services has reviewed this APMA notice about foot care coverage and confirmed the accuracy of its content. This notice is only a general summary of foot care exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.

Medicare Beneficiary Signature: X ______________________________ Date:

Signature

Authorization for Treatment and Release of Medical Information

I, the undersigned, do hereby authorize MARIAN DAVIS DPM PA to render treatment and/or therapy to myself that has been deemed medically necessary in order to treat the condition(s) I have requested from herself and her staff.

Patient/Guardian Signature: ________________________

Relationship of Guardian to Minor

X ________________________________
Signature

Legal Assignment of Benefits and Release of Medical and Plan Documents

In considering the amount of medical expenses to be incurred, I, the undersigned have insurance and/or employee health care benefits coverage with the enclosed caption, and hereby assign and convey directly to MARIAN DAVIS DPM PA all medical benefits and/or insurance reimbursement if any otherwise payable to me for services rendered from said doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within 90 days from the date of an insurance payment and/or denial. If outside collections are necessary, I will be responsible for all collection and legal fees. I hereby authorize the doctor to release all medical information necessary to process this claim within HIPAA guidelines. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to said doctor and clinic any plan documents, insurance policy and settlement information upon written request from said doctor and clinic in order to claim such medical benefits, reimbursement or applicable release.

I authorize the use of this signature on all my insurance or employee health benefit claim submissions. I have also received the HIPAA guidelines that the above named practice will follow and will have a signed receipt of these guidelines on file in the medical record. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee heath care plans on any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above name doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with said doctor and clinic in an attempt by said doctor and clinic to pursue such claims, choose in action or right against my insurers and employee health care plan including if necessary, bring suit with said doctor and clinic against insurers and employee health care plan in my name but at said doctors and

clinics expense. This assignment will remain in effect until revoked by me in writing. Photo of this assignment is to be considered as valid as the original. I have read and fully understood this agreement.

Insured/Guardian

x ______________________________
Signature

____
Relationship of Insured to Minor

Date:

CONSENT FOR PHOTOGRAPHY, VIDEOS, OR OTHER IMAGING

I consent for medical photographs or videos to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, publication, or advertisement. By consenting to these medical photographs/video/other imaging, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact the Office. I waive the right of prior approval and hereby release Dr. Imaze Marian Davis, DPM and his/her practice and any associated staff members from any and all claims for damages of any kind based on the use of my photographs/videos/other imaging information contained.

By signing below, I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Release.

Patient Name:

X ______________________________
Signature

Date: