MARYLAND PODIATRY CENTER

WELCOME TO THE PRACTICE!

How Did You Find Us?
Whom Can We Thank? _____

Patient Name:_____

Today's Date_____/_____/_____

Home Address_____ Apt/PO Box_____

City_____ State_____ Zip _____

Home Phone # (_____)_____ Cell Phone # (_____)_____

Work Phone # (_____)_____ Ext _____

E-Mail: _____

Date of Birth_____/_____/_____ Age_____ Sex: M / F

Emergency Contact:_____ Phone#_____

Relationship to patient:_____

Marital Status: Single Married Separated Divorced Widow(er)

Race (Circle): White Asian Black or African-American American Indian or Alaska

Native Native Hawaiian or Other Pacific Islander

Other or Refused to Answer:_____

Ethnicity (Circle): Hispanic Non-Hispanic Refused to Answer

Patient Employer:

Employer_____ Occupation:_____

Insurance Information

Who is the policy Holder? Patient _____ Other: _____
Relationship to Patient? _____
Primary Insurance Company_____
ID # _____ Group # _____
Policy Holder's Name:_____
Policy Holder's Date of Birth_____/_____/_____

Secondary Insurance Company _____
ID # _____ Group # _____
Policy Holder's Name_____
Policy Holder's Date of Birth_____/_____/_____

JOHN MURPHY, DPM FACFAS
3460 Ellicott Center Drive
Suite 103
Ellicott City, MD 21043

MARYLAND PODIATRY CENTER

FINANCIAL POLICY

Thank you for choosing our office to provide you with your foot and ankle needs. Our commitment to you will hopefully meet your expectations. The services provided by the office necessitate a financial responsibility from our patients. The following summarizes the financial areas of concern.

CO-PAYS: These payments will be collected each visit prior to being seen.
SELF PAY: If health insurance is not available, payment will be expect in full the day of service.

MEDICARE: The office participates with Medicare and the bill will be submitted for you, any co-pay or deductible will be the patient's responsibility, as stated by Medicare and secondary insurance.

SECONDARY INSURANCE: After payment from primary insurance is received, the secondary insurance company will be billed, as necessary.

REFERRALS/AUTHORIZATIONS: It is a legal agreement that we follow the guidelines of your insurance company. If you need a referral to be seen by a specialist, then it is your responsibility, not this office, to have it available the date of your visit. If a referral, which is required to be seen, is not present at the time of your visit, then the financial responsibility for services delivered will be placed on the patient. You have the option of rescheduling your appointment to a later date.

PATIENT BILLING: Please let the office know of any hardship you may have with payment of your bill. After the third notice to collect your responsibility of payment after the primary insurance and secondary insurance (if applicable) the account will be forwarded to a collection agency. Any returned checks will result in $30.00 added to your statement. Methods of payment include cash, Money Order, check or credit card.

PRIVACY STATEMENT
Any information disclosed in your records will remain confidential and will not be used for any reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

I have read the above policy regarding my financial responsibility to John Murphy, DPM LLC for providing medical services to me or the below named patient. I agree to pay any amount due after insurance payment has been made by my carrier and any contractual adjustments have been credited or the full amount of all bills incurred by me or the below named if no health insurance exists.

ASSIGNMENT OF BENEFITS
I, the undersigned, certify that I (or my dependent) have coverage with my insurance company as presented and assign directly to John Murphy, DPM LLC all insurance benefits payable to me for services rendered. I understand that I am responsible for all co pays, deductibles, and non covered services. I hereby, authorize the doctor to release all information necessary to secure payment of benefits. I authorize ***release of medical information*** to my insurance carrier or requested physician to provide continuity of care. I authorize this signature on all insurance submissions.

I understand it is my responsibility to inform my doctor of any change in my health insurance information.

Patient Name: _____ _____
Please Print *Signature* *Date*

FINANCIAL RESPONSIBLE PARTY (If different from patient):

NAME: _____
Please Print *Signature* *Date*

Relationship to Patient: _____

JOHN MURPHY, DPM FACFAS
3460 Ellicott Center Drive
Suite 103
Ellicott City, MD 21043
Tel: 410-992-8504

MARYLAND PODIATRY CENTER

Assignment of Benefits & Authorization to Release Information to My Insurance Company

I, the undersigned certify that I (or my dependent) have insurance coverage with the above plan(s), and hereby assign all insurance benefits, if any, otherwise payable to me, directly to John Murphy DPM for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance.
I herby authorize the doctor to release all information necessary to secure the payment of benefits from my insurance company(s).
I authorize the use of my signature below to reflect my agreement and authorize for the above for all insurance submissions.
Responsible Party Signature_____

Relationship_____

Date_____/_____/_____

Medicare Authorization
I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf directly to John Murphy, DPM for services rendered. I herby authorize the doctor to release to the Centers of Medicare and Medicaid Services (CMS) all information necessary to determine these benefits or the 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 in Section 9 of the HCFA 1500 claim form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-payment, and charges associated with non-covered services. Co-payments and deductibles are based upon the charge determination of the Medicare carrier.
Beneficiary Signature_____ **Date**____/____/____

USE AND DISCLOSEURE OF PROTECTED HEALTH INFORMATION
The HIPPA educational pamphlet provides information about how John Murphy, DPM, LLC may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996(HIPPA).

We reserve the right to change the items described. Should this happen, you will receive a revised copy. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you. By signing below, you acknowledge receipt of our HIPPA regulations.

Patient or Legal Guardian Signature_____
ACKNOWLEDMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(Effective Date: April 14, 2003)
(**NOTE: You have the right to refuse to sign this Form)
For professional Use Only
No signature above is for the following reason:
____Individual refused to sign
____Communication barrier prohibited obtaining a signed acknowledgment
____Emergency services prohibited obtaining a signed acknowledgment
____Specify other reasons_____

MARYLAND PODIATRY CENTER

MEDICAL FORM

The following information is very important to your health. Please be complete.

Patient_____ Date_____/_____/_____

Primary Physician _____ADDRESS_____ Telephone #_____

DATE LAST SEEN BY PRIMARY CARE PHYSICIAN (MM/YYYY):_____

AGE_____ Height_____ Weight_____ Shoe Size _____

CURRENT FOOT/ANKLE PROBLEM

In your own words, what foot/ankle brought you to our office today?

1._____

2._____

MEDICAL HISTORY

Please *check only what applies* for personal or family medical history of any of the following:

Problem	Yes, Personal History	Yes, Family History
AIDS/HIV	☐	☐
Anemia	☐	☐
Arthritis, osteoarthritis	☐	☐
Arthritis, rheumatoid	☐	☐
Asthma	☐	☐
Bleeding disorders	☐	☐
Cancer	☐	☐
Chest pain	☐	☐
Circulation problems	☐	☐
Cholesterol	☐	☐
Depression	☐	☐
Diabetes	☐ ____years	☐
Fibromyalgia	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Headaches, chronic	☐	☐
Heart (Surgery, Attack, Disease)	☐	☐
Heart Murmur	☐	☐
Hepatitis A, B, C	☐	☐
High blood pressure	☐	☐
Kidney problems	☐	☐
Liver disease	☐	☐
Nervous problems	☐	☐
Psychiatric disorders	☐	☐
Respiratory disease	☐	☐
Rheumatic fever	☐	☐
Stroke	☐	☐
TB	☐	☐
Ulcers, stomach, reflux (Circle one)	☐	☐
Other: _____	☐	☐

JOHN MURPHY, DPM FACFAS
3460 ELLICOTT CENTER DRIVE
SUITE 103
ELLICOTT CITY, MD 21043
TEL: 410-992-8504
FAX: 410-992-8509

MARYLAND PODIATRY CENTER

MEDICATIONS

Please list all prescription and over-the-counter medications including dosages:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

PHARMACY:_____**Phone:**_____

ALLERGIES ____ NKDA

Please check and describe any known allergies you may have and your reaction.

Adhesive tape	☐ _____	Aspirin	☐_____
Codeine	☐_____	Eggs	☐_____
Iodine	☐_____	Local anesthetics	☐_____
Novocain	☐_____	Penicillin	☐_____
Latex	☐_____	Shellfish	☐_____
Sulfa	☐_____	Other: _____	
Other: _____		Other_____	

List Surgeries **within the last 10 years**: _____

_____

_____

WOMEN:

Are you pregnant? YES_____ NO_____ Due Date_____

TOBACCO:

Current Y/N Packs/day_____ Years Smoking_____

Previously Y/N Packs/day_____ When did you Quit? _____

ALCOHOL:

Do you Drink Y/N Drinks/day_____ /Week_____ When did you Quit_____

ILLEGAL DRUG USE:

Current Y/N-Name_____ IV Drugs Y/N _____ Date of Last Use_____

CONSENT

I certify that the above information is true and correct to the best of my knowledge.

I give my permission for John Murphy, DPM to examine, photograph, administer and perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problems.

_____ _____

PATIENT OR GUARDIAN SIGNATURE Date

JOHN MURPHY, DPM FACFAS
3460 Ellicott Center Drive
Suite 103
Ellicott City, MD
Tel: 410-992-8504

MARYLAND PODIATRY CENTER

ACKNOWLEDGMENT 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 had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

If applicable only (for caregivers, guardians, or anyone who will be present in exam room)

I authorize _____

to be in the exam room during my treatments, participate in my care or have access to my records