ADVANCED WALK-IN FOOT CARE, PLLC

Dr. Walter H. Perez   Dr. Afsaneh Latifi   Dr. Lisa Wedderburn   Dr. Corrine Renne   Dr. David Tetrokalashvili
 Dr. Jeffrey Kriegel   Dr. Irina Pechalidi   Dr. Shauna Lewis Dr. Tetyana Boreesenko

Date: _____________ Who may we thank for referring you? ___________________________________

Patient's Last Name ____________________ First Name _______________________ Middle Initial____

Address _________________________________Apt. ____ City ________State____ Zip Code _______

Sex: ____M____ F Age ______ Birth Date ___________ SS #_____________________________

Home Phone ______________________ Cell Phone _________________Email:________________

Marital Status: Single_________Married_________Widowed _____________Divorced ________

Emergency contact: ______________________ Home Phone ______________ Cell Phone _________

Work Phone: ____________________________Occupation __________________________________

INSURANCE NAME: ________________POLICY# _______________________GROUP#________

Subscribers last name ________________First name ______________Relationship to patient ________

Subscribers Birth Date ______________ SS# ____________________Employer ____________________

SECONDARY INSURANCE NAME _______________ POLICY# ____________GROUP# _____

Subscribers last name ________________ First name _______________ Relationship to patient ______

Subscribers Birth Date _______________ SS# ____________________ Employer __________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ________________and assign directly to Dr. Walter Perez, or _____________, or Associates, all insurance benefit, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the doctor to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature ____Relationship _________________ Date________________

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Walter Perez or his associates for any services furnished me by these physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administrating and its agents any information needed 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 my claim. If "other health insurance indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electrically submitted claims, my signature authorizes releasing of the information o the insurer or agency shown. In Medicare assigned cases, the physician(s) or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature_____________________________________ Date ________________________________

Consent

I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet / and /or ankles

Patient's Signature ____ Date __________________________

ADVANCED WALK-IN FOOT CARE, PLLC

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize **Advanced Walk-In Foot Care, PLLC and Associates** to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see the copy of this form after I sign it. I understand that I may revoke this authorization at any time by given notice in writing at the address found above, but if I do it will not affect any actions taken before recipient of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient name: ____________________________Date of birth: __________________

Persons/organizations to receive this information:

____

Specific information to be released/disclosed is specified below:

Complete Medical Record, Or specify one or more of the following: Operative Reports, Progress Notes, Laboratory, X-rays, Billing and Claim Records. (Other-Specify)

____

This information is to be used/disclosed for the following purposes (s) only:

____

(No purpose need be stated if the request is made by the patient and the patient does not wish to state any purpose.)

This authorization will expire on_______________________ (state date or event)

______________________________ _________________

Signature of patient or patient's representative **Date**

(Form MUST be completed before signing.)

Printed name of patient's representative (if applicable): _________________

Relationship to the patient (if applicable): ___________________________

*** YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT ***

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 I understand the Notice

________________________________ ________

Patient Name (please print) Date

____

Parent or Authorized Representative (if applicable)

____

Signature