BEVERLY PODIATRY

Timothy J. Tobin, D.P.M.*/** • Lawrence E. McGinness, D.P.M.* • Rebecca R. Calder-Kelly, D.P.M.

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Patient Information Sheet – Confidential

Name _____ Sex _____ Date of Birth _____

Address _____ Age _____

City _____ State _____ Zip Code _____

Phone: ( ) - Email Address _____

Insurance _____ ID# _____

Emergency Contact _____ Phone ( ) -

Relationship _____

Pharmacy Information: **Pharmacy Name _____**

Address _____ City _____ State ____ Zip _____

Primary Care Information: **Name_____**

Address _____ City _____ State _____ Zip _____

Last PCP visit? _____

Medical Information

Are you Diabetic? Yes _____ No _____ Good Health? _____ Allergies _____

What is your present foot Problem? _____

_____

When did it begin? _____

What caused the problem or makes it worse? _____

Have you ever had any injuries or operation on your feet or legs? _____

Consent for Treatment

I hereby request and voluntarily consent to such office care, including routine diagnostic procedures and medical treatment as may be deemed necessary by Beverly Podiatry, Inc., and its designees.

Signature _____ Date _____

NAME _____

BEVERLY PODIATRY AUTHORIZATIONS SIGNATURE PAGE*

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

By signing below, I authorize the release of any medical or other information necessary to process my insurance claim(s). I also authorize payment of my insurance and/or Government Benefits be made directly to Beverly Podiatry which include but not limited to Timothy J. Tobin, D.P.M., Lawrence E. McGinness, D.P.M. and Rebecca R. Calder, D.P.M. whom accept assignments.

Signature _____ Date _____

NON-COVERED SERVICES WAIVER/NOTICE OF FINANCIAL LIABILITY

I accept full financial liability for all items or services which are determined by my health care service plan not to be covered, Services not specified as being covered in the patient's contract, charges that occur because of missing referrals, deductibles, copays, coinsurance, or because the patient is considered out of network. I understand and agree that it is my responsibility and obligation to obtain a referral if required, and to follow up with my Primary Care Physician Referral Department to be sure my referral has been sent in a timely manner.

Signature _____ Date _____

NOTICE OF HEALTH PRIVACY PRACTICES

I acknowledge that I have been offered and understand Beverly Podiatry's NOTICE OF PRIVACY PRACTICES. This notice describes how we use/disclose your healthcare information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected information. I understand that this Notice of Privacy Practices is available should I wish to take one home with me.

Signature _____ Date _____

MEDICATION HISTORY AUTHORIZATION

By signing below, I authorize Beverly Podiatry to have access to my Medication History.

Signature _____ Date _____

*if minor, please have parent/guardian sign.