Salt Lake City Podiatry
Podiatry/Foot and Ankle Surgery

Salt Lake City Podiatry
1250 E. 3900 S., Ste 420, Salt Lake City UT 84124
Phone: (801) 269-9939 Fax: (801) 269-9949

PATIENT INFORMATION

DATE: _____

PATIENT NAME: _____ ❑ MALE ❑ FEMALE

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

E-MAIL ADDRESS: _____

HOME PHONE: _____ REFERRED BY: _____

CELL PHONE: _____ PRIMARY CARE DR.: _____

WORK PHONE: _____ PREFERRED LANGUAGE: _____

ETHNICITY: ❑ HISPANIC or LATINO ❑ NOT HISPANIC or LATINO RACE: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

NAME: _____ ❑ MALE ❑ FEMALE

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

E-MAIL ADDRESS: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

EMPLOYER: _____ BUSINESS PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT

NAME: _____ ❑ MALE ❑ FEMALE

RELATIONSHIP: _____ PHONE #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY INSURANCE

COMPANY: _____ PHONE #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

NAME OF INSURED: _____ ID/SOCIAL SECURITY #: _____

DATE OF BIRTH OF INSURED: _____ RELATIONSHIP: _____

EMPLOYER OF INSURED: _____ PRE-AUTH #: _____

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PAYMENT INFORMATION

Payment is expected at time of service. Payment will be made by: CREDIT CARD, CASH or CHECK. If other payment arrangements are needed, please discuss your needs with Dr. Moritz. We try to accommodate the special needs of our patients. Discussing your needs with us will help avert future misunderstandings.

AGREEMENT TO PAY FOR MEDICAL SERVICES

In consideration of professional services rendered to the before mentioned patient, I/we agree to pay the customary charge for these services in full at the time of service, unless other arrangements have been made with Dr. Moritz. I/we authorize Dr. Moritz to receive assignment of insurance payment for services rendered. I/we agree to pay all coinsurance, copayments, and deductibles in accordance with insurance plan benefits and contracted rates.

I/we, the undersigned recognize that Dr. Moritz cannot accept responsibility for collecting any insurance claims or negotiating any settlement in a disputed claim. In the event of default in the payment of any amount due, I/we agree to pay interest at the rate of 1.5% per month on all past due balances from the original due date, plus court cost and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee if my account is assigned to a collection agency.

SIGNATURE: _____ DATE: _____
Signature of parent or guardian if patient is a minor

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

As of March 14, 2003, the HIPAA Compliance Act went into effect to protect your personal information, I have read and/or been offered a handout of these laws and regulations. I understand that the HIPAA Compliance Act of 2003 is to protect all my personal and medical information. Any and all information will only be shared with those individuals involved in my care.

I/we have read and understand the HIPAA PRIVACY PRACTICES NOTIFICATION and give the AUTHORATION TO RELEASE MEDICAL INFORMATION.

SIGNATURE: _____ DATE: _____
Signature of parent or guardian if patient is a minor

PRINTED NAME OF PARENT OR GUARDIAN IF PATIENT IS A MINOR: _____

MEDICARE BENEFICIARY SIGNATURE ON FILE

I authorize any holder of my medical or other information about me to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this related MEDICARE claims. I permit a copy of this authorization to myself or to the party who accepts assignments. Regulations pertaining to MEDICARE assignments of benefits apply.

SIGNATURE: _____ DATE: _____