AFPPodiatry

825 N Roselle Rd, Roselle, IL 60172
4701 N Cumberland Ave, Ste 19, Norridge, IL 60706
Roselle 630-582-100 Norridge 708-867-3338

PATIENT REGISTRATION

Male ☐ Female ☐

Patient Name _____ (last) _____ (first) _____ (middle initial)

Home Address _____ (street) _____ (apt. #) Home Phone (_____) (area code) _____

_____ (City) _____ (State) _____ (Zip)

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/er ☐ Dependant ☐

Birth date_____/____/_____Age_____ Social Security #_____

Primary Care Physician:_____ Referred by Attorney _____

Referred by Dr./patient/friend:_____ _____

Patient's Employer/School: _____ Drivers License # _____

Employment School_____ (street address) Occupation _____

_____ (city) (state) (zip) Phone _____

Parent / Spouse Name _____ Employer _____Phone _____

List any Allergies: _____

List any Current Medications: _____

BILLING INFORMATION

Name of person responsible for bill_____ (relationship) (social security #)

Address (if not as above) _____ (street) (city) (state) (zip)

Home Phone_____ Employer _____

Work Phone _____ Address_____

IN ORDER TO BILL YOUR INSURANCE, WE MUST HAVE A COPY OF YOUR CARD

PRIMARY INSURANCE	ANY OTHER INSURANCE
Ins. Co. Name _____	Ins. Co. Name _____
Subscriber Name _____	Subscriber Name_____
Date of Birth _____	Date of Birth _____
Group # _____ID# _____	Group # _____ ID# _____
Subscriber's Employer_____	

Does Your Insurance Carrier require a referral Yes ☐ No ☐

INJURY INFORMATION

Part of the body Injured _____ L ☐ R ☐ Date of Injury _____

How did the Injury Happen? _____ Employer at time of Accident_____

Where? Home ☐ Auto ☐ Work ☐ Sports ☐ School ☐ Other ☐ Claim Number _____

Name of Local Person not living with you _____ Relationship_____

Address _____ Telephone # _____

I request that payment of authorized Medicare or insurance benefits be made to my physician on my behalf for any services furnished to me. I authorize any holder of medical information about me to be released to my insurance company to process payment for medical services received. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment, and I accept financial responsibility for non-covered services.

_____Signature _____Date SIGN HERE

AFP Podiatry LTD

I _____The undersigned (the "Patient"), having healthcare benefit coverage through a group (including a self-funded and employer/employee benefit plan), Medicare, Medicaid and/or individual healthcare plan (collectively, the "Plan"), hereby appoint and assign as my designated authorized representative, AFP Podiatry, LTD (the "Provider"), and its billing agent, Katherine A Werner DBA Receivable Solutions and/or designated business associates, the right to pursue payment for all benefits entitled under my plan or policy. This authorization includes, taking any and all necessary steps, including pursing administrative appeals, requesting disclosures and remedies, filing suit and all causes of action and all other protected rights wholly in my stand, for benefit payment of all medical benefits otherwise payable to the Patient for medical services, treatments, therapies, and/or medications rendered or provided by the Provider, regardless of the Provider's managed care network participation status. The Patient hereby appoints the Provider, its billing agent, Katherine A Werner DBA Receivable Solutions and/or the Provider's appointed business associates, the Patient's rights, title, and interests in and to, and related to the recovery of, any and all benefits which the Patient is entitled to receive under the Plan or insurance policy, and authorizes the Provider to release all medical information necessary to pursue and process the Patient's benefits and claims thereunder. I certify that the health insurance information that I provided is accurate and that I am responsible for keeping it updated. I hereby authorize provider. to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) to be paid in full compliance of governing laws. I further authorize my plan, its fiduciaries, and/or its third-party administrators to release to my health care provider, its billing agent, Katherine A Werner DBA Receivable Solutions and/or the Provider's appointed business associates, all EDI and other information necessary for my healthcare provider to claim such benefits. I also hereby instruct my benefit plan (or its administrator) to pay the Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to provider, I hereby instruct and direct my benefit plan (or its plan administrator) to provide governing plan documentation stating such non-assignment to myself and the provider upon request and its standing to governing laws. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to the provider. I understand there are state and federal consumer protections that support even for out of network providers that may be associated with my care or surgery, that I am responsible for co-payments, co-insurance, and deductibles at no more than my in-network cost share rate. I understand, agree and hereby certify that I am obligated to pay, as charged and billed for global service charges, regardless if the above services are covered under my health insurance or plan. I understand that "Deductible" is defined, under the Uniform Glossary from ERISA & the Patient Protection & Affordable Care Act (ACA) as: "*The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay,*" and that I have no knowledge of any plan exclusion or limitation for the charges for healthcare services rendered by the above listed provider, in case that I can't afford to pay for 100% deductible. I understand the payments are due at the time of the services unless otherwise applicable to any PPO or ACA discount once my claim for benefits is processed in full compliance with plan terms and governing laws. I understand I am fully protected against any unexpected medical bills or charges by my provider's applicable ACA or indigency discount policy; including any non-compliant or arbitrary and capricious PPO Discounts or Re-pricing Discounts received from my health insurance plan. My satisfaction is guaranteed in connection with my provider's proactive reasonable efforts to collect or make a good faith determination for ACA Discount qualifications solely based on my unique ability to pay and individual health need. I hereby assign billed charges for healthcare services rendered as my legal claims to the above listed provider as full payment.

I agree to assist as needed in the with obtaining all benefits entitled and due me for all healthcare services rendered. I hereby designate, authorize and appoint the Provider, Katherine A Werner DBA Receivable Solutions, its attorneys or other designated business associate and as my authorized representative to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) To file and participate in any administrative or judicial review process; (4) to give the provider and its attorneys standing to pursue payment and file suit for benefits and any fiduciary breach and all causes of action available under ERISA and Section 502, 27 § U.S.C. 1132(a). (5) to pursue all necessary benefit payments, appeal rights, remedies and all causes of action, wholly in my stead; (6) to pursue a claim for benefits and to recover all applicable penalties for any fiduciary breach or failure by my plan, its fiduciary and/or its claims administrator to comply with 29 USC § 1132 and (7) allow a photocopy of my signature to be used to process insurance claims. This authorization will remain in effect until all benefits are paid in full compliance of applicable federal and state laws. I hereby confirm and ratify all actions taken by my authorized representative pursuant to the authority granted herein. I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to the above-named health care provider or its designated business associated any and all relevant Plan and claim related documents, requested disclosures, complete insurance policy, and/or settlement information upon written request from the provider, its attorneys or designated business associates in order to secure and claim such medical benefits due and owed me under my plan or policy. I authorize the release or disclosure of my protected health information to my authorized representative in order to secure and claim medical benefits due; (1) obtain information or submit evidence regarding the claim to the same extent as me; (2) make statements about facts or law; (3) act as my authorized representative in connection with filing, providing or receiving notice of any claim or appeal proceedings, to include any external review by applicable state or Federal External Review Process. I understand that I will be held financially responsible for all fees accumulated for collection agency fees. Administrative fees, attorney fees and court costs incurred by the provider listed above for any delinquent account requiring outside collection assistance, to the fullest extent of the law. This order will remain in effect until revoked by me in writing. I understand revocation of this appointment will not affect any action taken in reliance on this appointment before my written notice of revocation is received. Unless revoked in writing, this assignment is valid for any and all requested administrative and judicial reviews rightfully due me under my governing plan or policy and to the fullest extent permitted by law. A photocopy of this assignment is to be considered valid, the same as if it was the original. I understand that, by signing this form, I am confirming my appointment of my designated authorized representative, the scope of my authorized representative's authority, and the option of revoking of this appointment. I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____	_____	_____
Patient/Guardian/Insured Signature	Employer Group Name Covering Benefits	Date

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ASSIGNMENT OF BENEFITS AND PAYMENTS

Thank you for choosing AFP Podiatry, LTD as your podiatrist. We believe that part of good healthcare is to establish and communicate a financial policy to our patients. We are committed to providing you with quality and affordable health care. This financial policy will explain your responsibility for services given. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request. Payment is due at the time of service. Balance unpaid 90 days after services are rendered become the patient's responsibility and will be considered delinquent.

Payments owed at time of service: Your co-pay, your deductible, any co-insurance, and any non-covered services must be paid at the time of service. This arrangement is part of your contract with your insurance company. Please help us in upholding the law of your insurance company by paying the above at each visit.

A late payment charge will be added to an account if payment is not made within 60 days. The late payment charge is **1 ½ percent per month** on charges on paid within 60 days. The payment charge will be billed each month until those charges are paid **(at the rate of 18 percent per year)** and will appear separately on your regular statement.

I authorize payment for services rendered to me or my dependents to be paid directly to **AFP Podiatry, LTD**, from my insurance company, my attorney, or any other party who may become obligated to pay me any sums. I further authorize the endorsement of my name to any draft containing my name to which you are legally entitled. I understand that all charges incurred are the personal responsibility of the patient/guarantor. Commercial insurance is filed as a courtesy to the patient, and managed care insurance is filed with contracted carrier. The patient/guarantor is responsible for all residual balances including but not limited to co-pays, deductibles, co-insurance and services or charges not paid by insurance for any reason, after consideration of contractual adjustments.

In the event any insurance company, attorney, or other person obligated by contractual agreement to make payment to me for your service charges, refused to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against such company, attorney, or person and authorize you to prosecute said action either in my name or your name or for you to resolve said claim as you see fit. I understand that I shall continue to remain responsible for any uncollected or unpaid balance on my account.

I hereby direct my attorney not to interfere with or claim any lien upon, any medical payment benefits to which I may be entitled from either my health insurance or medical payment sources. And if any said medical payment checks include my attorney's name, I direct my attorney to sign his name to these checks for the benefit of the medical provider herein.

In the event that this account goes into default and our office turns it over to our outside collections agency/attorney for collections, it is accepted and agreed that thirty percent (30%) of the principal amount of the balance due will be added as collection/attorney fees.

It is also agreed and accepted that in the event that a lawsuit is filed, you, the patient will be liable for any and all court costs expended whether judgment has been entered or not.

Records. If you want a copy of your medical records, please refer to our HIPAA Privacy Policy. You will need to ask us for the Medical Record Request Form and return it fully completed before any copying of your records is done. This is a federal law. The fees are regulated by the State of Illinois.
Minor children: Please note that in the case of a minor child (under 18), the responsible party will be the parent that brings in the child regardless of any custodial agreement. It is your responsibility to make sure the bills and all balances owed at the time of service are paid at the time of service. Per law, once a minor child reaches the age of 18, they will be responsible for their own bills and records. They can elect to not allow a parent any access to their records. Please respect that this is the law.

AUTHORIZATION TO RELEASE INFORMATION

I authorize **AFP Podiatry LTD** and it's physicians to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment including disability related information to any third party payer (including Medicare), or their contracted agents, to validate or determine benefits payable for services rendered to myself or any dependents.

Signature _____

Date: _____

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AFP Podiatry LTD

LATE CANCELLATION / NO SHOW / RETURNED BOUNCHED CHECK POLICY

Due to the increased demand for appointment times, we have to implement a **Late Cancellation/ No Show Policy**. We regret that we have had to take these steps. Our concern for seeing our patients in a timely manner has prompted us to take these steps. We ask for a 24 hour notice for all cancellations.

If patients appointment has been confirmed and the patient fails to keep said appointment, there will be a fee assessed to the amount depending on the type of appointment scheduled; i.e., routine follow up $50.00 or procedure $75.00. Insurance will not cover charges for no-show or late-cancellation fees.

Payment of the NO-SHOW or late cancellation fee must be made in cash, or a valid credit card before further appointments are allowed.

Returned/Bounced Check. There will be a $50.00 charge for any returned or bounced check. You will be asked to bring cash, certified funds, or a money order to cover the amount of the check plus the returned check charge prior to receiving any future services from our staff or physician. Stop payments constitute a breach of payment and are subject to the $50.00 charge and collection action. All bad checks written to this office are subject to collections and will be prosecuted in either DuPage County or Cook County.

Please list below a valid credit card number.

_____ _____ _____

Visa/Mastercard/Discover/American Express Exp Sec Code

_____

Address City Zip Codes

I have read and fully understand my responsibility as patient.

_____ _____

Patient Signature Date