1150 Professional Court, Suite C
Hagerstown, MD 21740
(301) 797-8554

2100 Old Farm Drive, Suite D
Frederick, MD 21702
(301) 418-6014

Reconstructive Foot & Ankle Institute, LLC

PATIENT REGISTRATION – Please Print Clearly

PATIENT NAME Last	First	Middle	ACCOUNT #	SEX	MARITAL STATUS ❑ S ❑ M ❑ D ❑ W

DATE OF BIRTH	SOCIAL SECURITY NO.	HOME PHONE	CELL PHONE

HOME ADDRESS	APT NO	CITY	STATE	ZIP

REFERRED BY	FAMILY DOCTOR	FAMILY DOCTOR PHONE NUMBER	DATE OF ILLNESS/INJURY

EMPLOYER	WORK PHONE	PERSONAL E-MAIL ADDRESS

IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	WORK PHONE	HOME PHONE

SPOUSE'S NAME	SPOUSE'S EMPLOYER	SPOUSE'S WORK PHONE

PARENT OR LEGAL GUARDIAN IF PATIENT IS A MINOR

BILLING AND INSURANCE INFORMATION – CHECK ONE ❑ PERSONAL INJURY ❑WORKERS COMPENSATION ❑ AUTO INVOLVED INJURY

PRIMARY	INSURANCE COMPANY NAME	ID OR POLICY NUMBER	GROUP NUMBER
	INSURANCE COMPANY ADDRESS	SUBSCRIBER'S SOCIAL SECURITY #	SUBSCRIBER'S DOB
	SUBSCRIBER'S EMPLOYER	HOME PHONE	WORK PHONE
	EMPLOYER'S ADDRESS	WORK PHONE	EFFECTIVE DATE
SECONDARY	INSURANCE COMPANY NAME	ID OR POLICY NUMBER	GROUP NUMBER
	INSURANCE COMPANY ADDRESS	SUBSCRIBER'S SOCIAL SECURITY #	SUBSCRIBER'S DOB
	SUBSCRIBER'S EMPLOYER	HOME PHONE	WORK PHONE
	EMPLOYER'S ADDRESS	WORK PHONE	EFFECTIVE DATE

RELEASE OF MEDICAL INFORMATION FOR BILLING PURPOSES

I hereby authorize Reconstructive Foot & Ankle Institute, LLC to release medical information to my insurance carrier(s) for the sole purpose of obtaining payment for my medical care. I agree that a copy of this release may be used in place of the original.

PAYMENT FOR MEDICAL SERVICES

I hereby assume financial responsibility for all charges incurred for services rendered. I understand that I am responsible for all co-payments, co-insurances, deductibles and non-covered charges, paid in accordance with the benefits of my current insurance policy. If I am unable to make payment in full for my medical treatment within 30 days, I agree to call the billing office and make payment arrangements. It is further agreed that in the event I fail to pay upon demand, should my account be referred to a collection agency and or attorney, I accept full responsibility to pay all collection cost and interest of 1.5% per month not to exceed 18% per annum and reasonable court costs.

I hereby authorize payment for all medical insurance benefits which are payable under the terms of my insurance policy, to be paid directly to Reconstructive Foot & Ankle Institute, LLC.

I understand that I may be billed a no show fee for a missed or canceled appointment without a 24 hour notice.

I understand that all Durable Medical Equipment (DME) and Retail items dispensed to me are non-refundable and can not be returned unless there is a factory defect with the product: at which time Reconstructive Foot & Ankle Institute, LLC, will replace the defective item with a new item. I understand that my insurance has been billed for these items and do not hold Reconstructive Foot & Ankle Institute, LLC responsible for the disposal of any unwanted items.

I understand that my insurance company may be billed for a phone consultation, with my physician and I may incur a co-payment for this service.

_____ _____

Patient or Legal Guardian Signature Date

RELEASE OF MEDICAL INFORMATION FOR COORDINATION OF CARE

I hereby authorize Reconstructive Foot & Ankle Institute to release medical information to my referring physician, primary care doctor, case manager and any other individual involved in my medical care for sole purpose of facilitating my treatment. I understand that my medical information is confidential and that I have a choice to request that my physician not share my medical records with any of the above individuals. Should I choose to exercise this right I will provide in writing to my physician any of the individuals involved in my care to which I do not wish to receive my medical records. I agree that a copy of this release may be used in place of the original.

I am aware that I may request that this release of Medical information may be revoked at any time by providing the physician's office with a dated and signed letter.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The HIPPA educational pamphlet provides information about how Reconstructive Foot & Ankle Institute 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 terms described. Should this happen, you will receive a revised copy either by mail or in person.

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.

With consent Dr. Daniel Michaels, DPM, and/or his staff may discuss my protected health information, including course of treatment with the following individuals:

_____	_____
Name	Relationship
_____	_____
Name	Relationship

☐ NO DESIGNEE

ACCURATE HISTORY

I understand that honest and complete answers to each question stated below are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or member of the office staff for assistance.

_____	_____
Patient or Legal Guardian Signature	Date