HOMEWOOD SHOE HOSPITAL

2900 Central Avenue
Homewood, AL. 35209
(205) 879- 2329

PRIVACY NOTICE

Homewood Shoe Hospital is dedicated to protecting the privacy of each and every patient. It is your right to receive quality care without concern that your personal health information (PHI) will be shared and disclosed to others. Your medical information is protected by law and will only be used in treatment, payment, and health care operations. Employees of Homewood Shoe Hospital and affiliated business associates have signed confidentiality statements and contractual agreements agreeing to follow the policies and procedures of our practice in protecting your privacy. While disclosures of PHI to doctors, nurses, trainers, and/or coaches is often necessary for treatment, your information will not be sold to any outside agency nor will it be released for any other reason than treatment, payment, health care operations, or when required by state or federal laws without your written consent.

FINANCIAL POLICY

We strive to provide the highest quality professional care to our patients. If you are covered by Blue Cross and Blue Shield or Workman's Compensation, we will be happy to submit a claim for you. Your insurance will be billed at the time of delivery. You are responsible for any amount not covered by insurance including payment of any outstanding co-pays, co-insurance, or deductibles.
Please call to cancel or reschedule appointments within 24 hours of your appointment.
For all other insurance, or if you do not have insurance, you are responsible for payment of footwear, including orthoses, at the time of your initial visit. We accept cash, checks, and most credit cards.
Medicare does not pay for Foot Orthotics/Inserts (NonDiabetic) or Custom Orthopedic Shoes (NonDiabetic).
You will be responsible for payment on these items at the time of your initial visit.
We will be happy to answer any questions you may have concerning our financial policy.

Patient Agreement: I understand Homewood Shoe Hospital's financial policy as written above and agree to abide by it. I understand that I am responsible for any amount not covered by insurance. I agree to pay all cost of collection including a reasonable Attorney's Fee, should this be account be placed with an attorney.

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE INFORMATION

I, request that payment of authorized private insurance benefits be made payable to Homewood Shoe Hospital for any covered services furnished by Homewood Shoe Hospital. I agree to pay Homewood Shoe Hospital the deductible and/or co-insurance on my claim. I authorize any holder of medical information about me to release any private insurance company any information needed to determine these benefits or the benefits payable for related services. I further certify that the information provided by me is true, accurate, and complete.
If this is a private claim, I further agree to be responsible for the full amount of the charges from the date of delivery if my private insurance company does not pay for the charges in a timely manner, within 30 days, the information necessary to submit the claim for payment.

PATIENT PRINTED NAME: _____
PATIENT SIGNATURE: _____

New Patient Information

Mr. Mrs. Miss _____ Date of Birth_____

Home Address_____City _____St_____ Zip_____

Home Phone _____Cell Phone_____Work Phone_____

Email Address _____Preferred Name_____

Social Security Number _____-_____-_____Spouse/Parent/Guardian Name_____

Spouse/Parent/Guardian Phone _____Work or Cell_____

Referring Physician's Name: _____ Date of Injury: / /

Your Employer: _____ Occupation:_____

Emergency Contact Name _____Relationship_____ Number_____

How did you hear about us? _____

Date of last orthotics _____How many pair _____

Medical Information

Are you diabetic? Yes No

---If Yes, Name of Dr. treating your Diabetes: _____ Type _____

Referring Physician_____ Number_____

Insurance Information

Primary Insurance_____ Name of Policy Holder _____

Relationship _____

Policy #_____ Group #_____

Policy Holder Date of Birth _____

Reserved for Staff

Reserved for Staff

MEDICAL HISTORY FORM

Name _____ Birthdate _____

Do you exercise regularly? _____ if YES, what do you do? _____

How much (or how long)? _____

What brings you to see us today?

_____

How long has this been going on?

_____

Are you allergic to latex or any other kind of rubber material? YES NO

What do you do for a living?_____ Does this require standing? YES NO

If YES, how long? _____

Primary Care Physician Name: _____

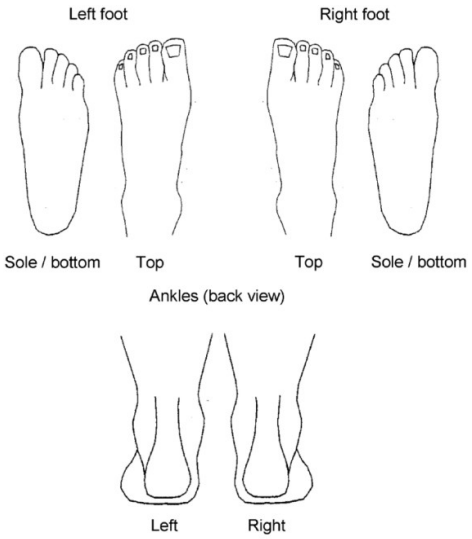
Address & City:

_____Phone:_____

Have you had any of the following illnesses: (Please Circle)

Neuropathy	Active Ulcer	Poor Balance	Ingrown Nails
Knee Problems	Neuroma	Hip Problems	Hepatitis
Heel Spurs	Allergies	Arch Problems	Diabetic Type: 1 2
Eczema	Overlapping Toes	Bunions	Low Blood Pressure
Seizures	Plantar Fasciitis	High Blood Pressure	Leg Length Discrepancy

(Circle Pain)



Leg Length Discrepancy? YES/NO

if YES, what leg? LEFT RIGHT

How much of LLD? _____

_____

Signature

_____

Date