New Patient Enrollment Form

Facility Name:_____ **Room Number:** _____ **Admit Date:** _____

Patient Name:_____ **DOB:**_____ **SSN:**_____

Sex: Male (M)_____ **Female (F)** _____ **Race:** _____ **DNR or Full Code:**_____

Home Number: ( ) _____ **Cell Number: ( )** _____

Address: _____

Insurance:_____ **Policy Number:**_____

MUST include a copy of front and back of ALL insurance cards

Allergies:

Responsible Party Information:

Name:_____ **Relationship:**_____

Address:_____

Home Number: ( ) _____ **Cell Number: ( )** _____

1st Emergency Contact

Name:_____ **Relationship:**_____

Home Number: ( ) _____ **Cell Number: ( )** _____

2nd Emergency Contact

Name:_____ **Relationship:**_____

Home Number: ( ) _____ **Cell Number: ( )** _____

- **Please send an updated MAR and Diagnosis Information sheet**
- **Please send a Copy of Driver's License and Social Security Card**
- **Please include copies of front and back of ALL Insurance cards**

_____ _____

Signature of Responsible Party ***Date***

RETURN THIS FORM TO WRIGHT PODIATRY

Consent to Release Medical Records

From: _____

_____

_____

Please disclose the following information:	To be used for the following purposes:
o Medical Records o Treatment Records o Lab/Diagnostic Records o Other _____	o Per Patients Request o Coordinated Care o Transfer of Care o Other _____

I understand that the information I have agreed to release to the aforementioned party may include sensitive clinical information obtained during the care. These may or may not include substance abuse, other abuse, HIC, psychiatric disorders, sexually transmitted diseases, etc. unless herein excepted:

_____

By signing below, I hereby authorize and request that you release my medical records and/or other information concerning my healthcare and/or treatment to:

ADDRESS HERE

I also understand that I may revoke this authorization at any time by submitting a written notification to the address above. This notice will not apply to the actions taken prior to the date my revocation of authorization is received. I understand that this authorization expires twelve months from the authorization date, unless the need for disclosure is satisfactorily met within that twelve-month period or if I provide written revocation of this authorization.

PATIENT AUTHORIZATION

Patient Name:_____ Date of Birth: _____

_____ Date:_____

Signature of Patient or Authorized Representative

RETURN THIS FORM TO WRIGHT PODIATRY

Financial, Insurance and Provider Acknowledgement Form

(Please fill out and sign the form below to be *returned* with your enrollment and other required forms)

Printed name of patient: _____

Services for Enrollment with Wright Podiatry (please check all that apply)

Podiatry Services ☐

Please sign the consent below (if checked above for services):

I have read and acknowledge the terms for each form: _____

Podiatry services consent to treat: _____

Witness/Facility Representative: _____

Date: _____

Please acknowledge that you have read and agree to the terms of the Patient's Financial Responsibility form by signing below. (*Please keep the Patient Financial Responsibility Statement forms for your records*)

_____ _____

Signature Date

i. I have been provided a copy of the Wright Podiatry ***Patient Financial Responsibility Statement***
ii. I have read, understand, and agree to their provisions and agree to the specific terms
iii. I agree to pay all charges due (or to become due) to Wright Podiatry for the below Patient's care and treatment, including copayments, coinsurance, deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable
iv. Benefits, if any paid by a third-party will be credited on the patient's account
v. Regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered
vi. If I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys' fees (to the extent allowed by law)
vii. Failure to pay when due may subject me to late payment charges and can adversely affect my credit report. I further agree that a photocopy of the ***Patient's Responsibility Financial Statement*** will be as valid as the original.

RETURN THIS FORM TO WRIGHT PODIATRY

Authorization For Medical Treatment Agreement

I,_____ A RESIDENT AT _____

HEREBY AUTHORIZE_____ AND/OR WHOMEVER MAY DESIGNATE AS AN ASSISTANT TO ADMINISTER SUCH TREATMENT OR PERFORM ANY DIAGNOSTIC OR THERAPEUTIC MEASURES TO BE UNDERTAKEN AT THE SAID FACILITY AS IS NECESSARY DURING MY STAY AT SAID FACILITY. IN THE EVENT OF A MEDICAL EMERGENCY, I CONSENT TO BE TREATED BY ANY ATTENDING PHYSICIANS IN ATTENDANCE AT THE LOCAL HOSPITAL OR ON THE BEHALF OF WRIGHT PODIATRY.

I HEREBY AUTHORIZE AND DIRECT THE CENTERS FOR MEDICARE, MEDICAID SERVICES, AND PRIVATE INSURANCE PROVIDERS TO ISSUE PAYMENT OF BENEFITS DIRECTLY TO WRIGHT PODIATRY. I ACCEPT RESPONSIBILITY FOR ANY UNPAID PORTIONS FROM SERVICES RENDERED. I ALSO AGREE TO FORWARD ANY PAYMENTS MADE TO ME BY MY INSURANCE COMPANY TO WRIGHT PODIATRY.

I HEREBY AUTHORIZE ANY INFORMATION OR MEDICAL INFORMATION ABOUT ME NEEDED TO DETERMINE THESE BENEFITS OT THE BENEFITS PAYABLE FOR RELATED SERVICES TO BE RELEASED BY WRIGHT PODIATRY TO THE CENTERS FOR MEDICARE, MEDICAID SERVICES, AND MY PRIVATE INSURANCE PROVIDERS.

I HEREBY CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE AUTHORIZATION FOR MEDICAL TREATMENT.

_____ _____

WITNESS/FACILITY REPRESENTATIVE ***DATE***

_____ _____

PRINTED NAME OR RESIDENT OR RESPONSIBLE PARTY ***DATE***

_____ _____

SIGNATURE OR RESIDENT OR RESPONSIBLE PARTY ***DATE***

(*THE FACILITY AND RESIDENT/RESPONSIBLE PARTY NEEDS TO KEEP A COPY FOR THEIR RECORDS*)

Patient Financial Responsibility Statement

Thank you for choosing Wright Podiatry as your healthcare provider. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign the attached ***Financial, Insurance and Provider Acknowledgement Form***. Feel free to ask if you have any questions regarding your financial responsibility. If someone else (*parent, spouse, domestic partner, etc.*) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, copayments, coinsurance, and patient billing. By accepting to receive medical services from Wright Podiatry, you agree:

1. You acknowledge and agree to the established policies and procedures of Wright Podiatry, including but not limited to this ***Patient Financial Responsibility Statement***.
2. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for your deductible, copayments, coinsurance amounts or any other patient responsibility indicated by your insurance carrier or our policies, which are not otherwise covered by supplemental insurance.
3. You are responsible for knowing your insurance policy and providing insurance information to Wright Podiatry.
4. By signing the attached ***Financial, Insurance and Provider Service Acknowledgement Form***, you authorize Wright Podiatry to verify your insurance benefits and submit your claims to your insurance carrier or other plan provider. You agree to facilitate payment or claims by contacting your insurance carrier or other plan provider when necessary. Without waiving any obligation to pay, you assign to Wright Podiatry, for application onto your bill for services, all of your rights and claims for the medical benefits to which you, or your dependents are entitled, under any federal or state healthcare plan (*including, but not limited to, Medicare or Medicaid*), insurance policy, any managed care arrangement or other similar

third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you. You authorize Wright Podiatry and associated physicians, staff and hospitals to release patient information acquired in the course of your examination and/or treatment including but not limited to any and all medical records, notes, test results, ALL radiology reports or other documents related to your treatment (*including itemization of any charges and payments on your account*) that is deemed necessary to process your claim to the necessary insurance companies, third party payors, and/or other physicians or health care entities as they require to participate in your care. It is important to notify us as soon as possible of **any** changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you may be held responsible for the balance of the claim. Wright Podiatry does not accept responsibility for incorrect information given by you or your insurance carrier or other plan provider regarding your insurance benefits or benefit plans.

5. **Authorization to Contact**. You authorize Wright Podiatry personnel to communicate by mail, answering machine messages, cell phone messages, and/or email according to the information provided in your patient registration information. Wright Podiatry, or any agent or servicer of your patient account, may use any information you have provided, including contact information, email addresses, cell phone numbers, and landline numbers, to contact you for purposes related to your account, including debt collection. You authorize Wright Podiatry to use this information in any manner consistent with the information you have provided, including mail, telephone calls, emails, or text messages. You expressly consent to any such contact being made by the most efficient technology available, including automatic dialing/emailing or similar equipment, or pre-recorded or other messages.
6. **Financial Responsibility Party.** If this or a separate Medical Associates Financial Responsibility Statement is signed by another person, on your account, then that co-signature remains in effect until canceled in writing. Cancellation in writing shall become effective the date after receipt, and
7.

8. shall apply only to those services and charges thereafter incurred. By signing as Financial Responsibility Party, you hereby guarantee the full and prompt payment to Wright Podiatry of all indebtedness of Patient to Wright Podiatry, whether now existing or hereafter created (the "Indebtedness"); and you further agree to pay all expenses, legal or otherwise, incurred by Medical Associates in collecting the Indebtedness, in enforcing this guaranty, or in protecting its rights under this guaranty or under any other document evidencing or securing any of the Indebtedness. This guarantee shall be continuing, absolute and unconditional guarantee, and shall remain in force and effect until any, and all said Indebtedness shall be fully paid. There shall be no obligation on the part of Wright Podiatry at any time to first exhaust its remedies against the patient, any other party, or any other rights before enforcing the obligations of the Financial Responsibility Party.

7. **Acknowledgement:** By signing the attached ***Financial, Insurance and Provider Service Acknowledgement Form***, each of the undersigned acknowledges that

i. I have been provided a copy of the Wright Podiatry ***Patient Financial Responsibility Statement***
ii. I have read, understand, and agree to their provisions and agree to the specific terms
iii. I agree to pay all charges due (or to become due) to Wright Podiatry for the below Patient's care and treatment, including copayments, coinsurance, deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable
iv. Benefits, if any paid by a third-party will be credited on the patient's account
v. Regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered
vi. If I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys' fees (to the extent allowed by law)

vii. Failure to pay when due may subject me to late payment charges and can adversely affect my credit report. I further agree that a photocopy of the ***Patient's Responsibility Financial Statement*** will be as valid as the original.

(*THE FACILITY AND RESIDENT/RESPONSIBLE PARTY NEEDS TO KEEP A COPY FOR THEIR RECORDS*)