FISHER CLINIC

Patient Registration Form

Patient Name: _____

Date of Birth: _____ SSN_____-_____-_____ Sex:____

Occupation: _____

Preferred Contact Number: (_____) _____-_____ cell / home / work

Alternate Contact Number: (_____) _____-_____ cell / home / work

Mailing Address: _____

City: _____ State: _____ Zip: _____

Family Doctor:_____ Date of last visit:_____

Preferred Pharmacy:_____

If not the patient, who is the financially responsible person:

Name: _____

Relation to Patient: _____

Address, if different: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____

Telephone Number: (_____) _____-_____ Relationship: _____

You may share my health information with (lab results, appointments info, etc,)

With:

_____

_____

Fisher Foot Clinic
Dr. Courtney Bordenkcher

Primary Insurance Carrier: _____

Subscriber ID: _____

Secondary Insurance Carrier: _____

Subscriber ID: _____

Tertiary Insurance Carrier: _____

Subscriber ID: _____

Medical History

Height: _____ Weight: _____ Shoe Size: _____

Allergies

___ Adhesive ___ Aspirin ___ Codeine ___ Iodine ___ Latex ___ Morphine

___ Novocaine ___ Penicillin ___ Sulfa ___ Other:_____

Medications:_____

_____

_____

Medical Problems

___ Alzheimer's
___ Anemia
___ Angina/Chest Pain
___ Anxiety
___ Arthritis
___ Back Pain
___ Cancer
___ COPD
___ Diabetes
___ Dialysis
___ Glaucoma
___ Gout
___ Headaches
___ Hearing Aids
___ Heart Attack
___ Heart Failure
___ Hepatitis
___ High Blood Pressure
___ Hypothyroidism
___ Impaired Vision
___ Kidney Stones
___ Leg Pain/Cramping
___ Neuropathy
___ Paralysis
___ Acid Reflux/GERD
___ Respiratory Problems
___ Ringing in Ears
___ Seizures/Epilepsy
___ Skin Cancer
___ Stroke/Mini-stroke
___ Varicose Veins
___ On Blood Thinners

Family History

___ Cancer ___ Diabetes ___ Heart Disease ___ High Blood Pressure

Surgical History

___ Appendectomy ___ Cataract ___ Hysterectomy ___ Open Heart Surgery

___ Cancer Surgery ___ Hernia ___ Knee ___ Tonsillectomy

___ Cardiac Cath ___ Hip ___ Gall Bladder ___ Tubal Ligation

___ Other:_____

Social History

___ Exercise ___ Drink Alcohol ___ Smoke Cigarettes/Cigars

Financial Policy

Thank you for choosing Fisher Foot Clinic for your care. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we developed this payment policy. Please read it, ask us any questions you may have, and initial and sign in the spaces provided. A copy will be provided to you upon request.

____ **Co-payments and deductibles** All co-payments and deductibles are due at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. Fisher Foot Clinic reserves the right to refuse treatment if you fail to pay a known copay or deductible at the time of service.

____ **Non-covered services** Please be aware that some – and perhaps all – of the services you receive may be non covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for the balance of these services.

____ **Proof of insurance** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your identification and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

____**Claims submission** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

____ **Coverage changes** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 60 days, the balance will automatically be billed to you.

____ **Payment Plan** Fisher Foot Clinic recommends you enroll in our Card on File Billing Agreement to manage your medical bill. If you cannot pay your bill in full please contact the office immediately. We can work with you to set up a payment plan to keep you in good standing.

____ **Nonpayment** If your account is over 30 days past due, counted from the date of the earliest visit from which you have a balance, Fisher Foot Clinic reserves the right to refuse treatment for non emergencies. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

____ **Missed appointments** Our policy is to charge $25 for missed appointments not canceled at least 24 hours prior to your appointment time . These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

____ **Returned Check Fee** There will be a $30 fee for a returned check. If you have a returned check you must make all future payments by cash or card.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

Fisher Foot Clinic

Dr. Courtney Bordenkecher

CONSENT TO TREATMENT, ASSIGNMENT OF BENEFITS AND PRIVACY POLICY

Consent to Treat

I authorize the medical staff, nursing staff and other personnel of Fisher Foot Clinic to provide care, and to administer such diagnostic, radiological and/or therapeutic procedures and treatments as the medical staff determines is necessary or advisable in my care. If I am signing this document on behalf of another person, I acknowledge that I am consenting on behalf of the patient and I will indicate my relationship to the patient where indicated below.

Assignment of Benefits

I hereby irrevocably assign and transfer to Fisher Foot Clinic any monies or benefits to which I may be entitled, including benefits/monies from governmental payers such as Medicare, my insurance company, HMO, or other third parties who are financially responsible for my medical care. I authorize and direct Fisher Foot Clinic and its physicians, having treated me, to release to such payers or other third parties who are financially responsible for my medical care, all information needed (including but not limited to medical records, copies of claims and itemized bills) to substantiate payment for my medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I also appoint Fisher Foot Clinic as my authorized representative to pursue all rights of payment, to ascertain the benefits available, to collect benefits directly from my insurance company and to appeal denials on my behalf if for any reason my insurance company refuses to pay my claim. I further agree to provide information as necessary and to cooperate with Fisher Foot Clinic to process and obtain payments.

Patients Entitled to Medicare Benefits

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release it to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers for the purpose of payment. I request that payment of authorized benefits related to my care be assigned to Fisher Foot Clinic.

Privacy Policy

I acknowledge that I was given the opportunity to read the Notice of Privacy Practices. It is posted in the waiting room lobby and available online at Fisherfootclinic.com.

_____	_____	_____	_____
Patient//Relative/Guardian* (Signature)	Date	Print Name	Relationship, if other than patient

Fisher Foot Clinic
135 Express Lane
Orangeburg, SC 29118

Chart Number _____

Patient Email and Text Message Informed Consent

Fisher Foot Clinic and its affiliates, agents, independent contractors and any "covered entity" or "business associate" (as those terms are defined in the HIPAA Privacy Rule) with which your information may be shared under HIPAA (collectively, "Fisher Foot Clinic") may communicate with you by email, text message, and/or other forms of unencrypted electronic communication (together, "Electronic Messaging") to the telephone number(s), email address(es) or other locations reflected on your account or as otherwise provided below. This form provides information about Fisher Foot Clinic's use, risks, and conditions of Electronic Messaging. It also will be used to document your consent for Fisher Foot Clinic's communication with you by Electronic Messaging.

How we will use Electronic Messaging: Fisher Foot Clinic may use Electronic Messaging to communicate with you regarding a wide range of healthcare related issues, including:

• reminders of appointments or actions for you to take before an appointment, follow-ups from appointments, and notices about preventive services, treatment options, coordination of your care and other available health services;
• how to participate in patient satisfaction surveys or how to use our secure patient portal; and
• information regarding insurance, billing, eligibility for programs/benefits, and account balances. Fisher Foot Clinic may use automatic dialers or pre-recorded voice messages when it communicates with you through Electronic Messaging. All Electronic Messaging may be made a part of your medical record.

Risk of using Electronic Messaging: Electronic Messaging has a number of risks that you should consider, including:

• Electronic Messaging can be circulated, forwarded, sent to unintended recipients, and stored electronically and/or on paper.
• Senders can easily misaddress Electronic Messaging and send the information to an unintended recipient.
• Backup copies of Electronic Messaging may exist even after deletion.
• Electronic Messaging may not be secure and can possibly be intercepted, altered, forwarded or used without authorization or detection.
• Electronic Messaging service providers may charge for calls or messages received.
• Employers and online providers have a right to inspect Electronic Messaging sent through their company systems.
• Electronic Messaging can be used as evidence in court.

Conditions for the use of Electronic Messaging: Fisher Foot Clinic cannot guarantee, but will use reasonable means to maintain, the security and confidentiality of the messages we send. By signing where indicated below, you acknowledge your consent to the use of Electronic Messaging on the following conditions:

• **IN A MEDICAL EMERGENCY, DO NOT USE ELECTRONIC MESSAGING, CALL 911**. Urgent messages or needs should be relayed to us by using regular telephone communication. Non-urgent messages or needs should be relayed to us by using regular telephone communication or our secure patient portal.
• Electronic Messaging may be filed into your medical record.
• Fisher Foot Clinic is not liable for breaches of confidentiality caused by you or any third party.
• You are solely responsible for any charges incurred under your agreement with your Electronic Messaging service provider (for example, on a per minute, per message, per unit-of-data-received basis or otherwise).

Expiration and Withdrawal of Consent: Unless you earlier withdraw your consent, this consent will expire upon the end of your treatment relationship with Fisher Foot Clinic. You may choose to stop participating in Electronic Messaging at any time by informing Fisher Foot Clinic in writing as described herein. You further understand that withdrawing this consent will not cause you to lose any benefits or rights to which you are otherwise entitled, including continued treatment, payment or enrollment or eligibility for benefits. To withdraw consent and stop participating in Electronic Messaging, please contact the Fisher Foot Clinic.

Patient Acknowledgement and Agreement: I have read and fully understand this consent form. I understand the risks associated with the use of Electronic Messaging between Fisher Foot Clinic and me, and I consent to the conditions and instructions outlined, as well as any other instructions that Fisher Foot Clinic may impose to communicate with me by Electronic Messaging.

I understand that Fisher Foot Clinic will send Electronic Messaging to those telephone number(s) and email address(es) in my account:

____ I consent to receive text messages at this cell phone # _____

____ I consent to receive e-mail messages at this email address _____

Release. In consideration of Fisher Foot Clinic's services and my request to receive Electronic Messaging as described herein, I hereby release Fisher Foot Clinic from any and all claims, causes of action, lawsuits, injuries, damages, losses, liabilities or other harms resulting from or relating to the calls or messages, including but not limited to any claims, causes of action, or lawsuits based on any asserted violations of the law (including without limitation the Telephone Consumer Protection Act, the Truth in Caller ID Act, the CAN-SPAM Act, the Fair Debt Collection Practices Act, the Fair Credit Reporting Act, the Health Insurance Portability and Accountability Act, any similar state and local acts or statutes, and any federal or state tort or consumer protection laws).

_____ _____

Patient (or Authorized Representative) Signature Patient's Printed Name

Account #(Office Use)_____

If you have Medicare or a Medicare Advantage Plan, you may skip this page.

Credit Card on File Billing Authorization Form

Fisher Foot Clinic is offering a secure and convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed to and processed by your insurance carrier, and the insurance portion of the claim has been posted to your account, or in the event that valid insurance information was not provided at the time of service.

I,_____ , authorize Fisher Foot Clinic to capture my credit card information and securely store my credit card on file.

I authorize Fisher Foot Clinic to charge my credit card on file for any balance owed on this account up to $_____ ($150 by default) per month until my balance is satisfied.

I agree Fisher Foot Clinic may charge my credit card on file for the balance due when they receive a copy of my Explanation of Benefits statement from my insurer. This authorization relates to all balances not covered by my insurance company for services provided by Fisher Foot Clinic. This could be amounts resulting from balances related to copayment, deductible, co-insurance, non-covered services, or denials for no coverage/eligibility but is not limited to these scenarios.

I understand that this form is valid until I give a 30-day written notice to cancel the authorization to Fisher Foot Clinic. Written notice must be submitted to Fisher Foot Clinic 135 Express Lane, Orangeburg, SC 29118.

I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Patient Name:_____

Card Holder's Name (as shown on Card:) _____

__ Visa __ Mastercard __ Discover __ American Express

Credit Card Number _____

Expiration ____/____ CVV _____ (on back of card)

Email:_____

_____ _____

Cardholder Signature Date

Credit Card on File Billing Authorization FAQ - Keep for your reference

Q: Who do I call if I have any questions?
A: You can call our Billing Manager at 803-585-7900

Q: How does the automatic billing process work?
A: Your credit card will be captured today and stored securely. After your insurance carrier responds and provides us your remaining balance due we may charge the patient responsibility to your credit card on file, not to exceed the maximum balance due indicated in the agreement. Your credit card on file will only be charged when you have a balance owing on your account or for a non-covered service.

Q: When will my card be charged?
A: Your card will be charged on or about the 15th of the month after we have received an explanation of benefits from your insurance carrier, usually one week to one month after your visit. If your balance is not satisfied by the payment limit you set, your card will be charged up to your payment limit on or about the 15th of the next month until your balance is satisfied.

Q: How will I know how much you are going to charge me?
A: You will receive an Explanation of Benefit from your insurance carrier that explains exactly, according to your health insurance coverage and benefits, how much of your healthcare bill is your responsibility and how much the insurance paid along with any contractual adjustments.

Q: What if I need to dispute my bill?
A: We will always work with you to resolve any issues and will refund you if we have made a billing error. We will only charge the amount that we are instructed by your insurance carrier to collect from you in the same way that we normally determine how much to send you a statement for in the mail. If you disagree with how your insurance carrier processed the claim you will need to contact their customer service department directly.

Q: Will I receive a statement or receipt for the charges automatically billed to my card?
A: Yes so long as you provide a valid email address. Your insurance carrier will also send an explanation of benefits that will detail how much you are expected to owe. You can at any time contact us to have an itemized statement mailed to you.

Q: What is a deductible?
A: An annual deductible is the dollar amount you must pay out of your own pocket during your plan year for medical expenses before your insurance begins to pay. For example, if the policy has a $1,000 deductible, you must pay the first $1,000 of medical expenses before your insurance will begin to pay. Your insurance company must receive a claim to process in order to apply balances towards your deductible. Even if you have a high deductible plan we encourage you to have us submit the claim to your insurance so you receive a contractual adjustment and the services can be applied towards your deductible.

Q: Is my credit card secure?
A: Yes, we do not keep a physical copy of your sensitive credit card information in our office. Your information will be stored on the encrypted system we are already using to protect your medical records.