PODIATRIC RECORD

This complete record is confidential

Medical Alerts	Patient's Name			Today's date	
				Age	Birthdate
	Residence Address	City		State	Zip
	Home Phone	Social Security No.		Medicare #	
Patient	Spouse's Name/Parent or Guardian's Name if a Minor				
Employed by	Occupation	Business Phone			
Whom may we thank for referring you?		PRIMARY CARE PHYSICIAN'S NAME:		DATE LAST SEEN:	

Name, address and phone of contact in case of emergency

If other than patient, name and address of person responsible for this account

Subscriber Date of Birth:

Do you have Medical Ins? ☐ Yes ☐ No	Carrier Name	Subscriber Name	Policy No.	Group No.
Is it through your employer? ☐ Yes ☐ No	Is there secondary ins.? (Spouse, Medicare, etc.) ☐ Yes ☐ No	Carrier Name	Subscriber Name	Policy No.

Subscribers Employer:____________________________**(required by Insurance Co)**

Address: ____________________________

Telephone Number____________________________

Is Your Foot/Ankle Problem due to an injury ? _______ **No** _______ **Yes** **Date of Injury** ______________

If yes, is it: _______ **Job Related** ______ **Auto Accident** _______ **or other** ____________________

Have you been provided a specific case number by your supervisor? ____**NO** ___**YES Case #** ________________

Payment Policy

Payment for services is the responsibility of the patient and due upon the completion of the visit. In case of Managed Care Insurance plans (ex. HMOs, PPOs) **the patient is fully responsible for obtaining the appropriate referral forms prior to the office visit to qualify for care and insurance coverage.** If an HMO referral is not available at the time of the visit, the patient will be fully responsible for all charges related to the visit. Our office is not held responsible by the Managed Care Insurance plans for obtaining the initial consultation or referral forms. This is the patient's responsibility. However we will provide reasonable assistance in obtaining appropriate follow up referrals where indicated.

Patient Payment Authorization

A $50.00 fee will be charged to patients for missed visits without 24 hour notice

____X____ **I understand that I am responsible completely for payment of charges for Medical services rendered by Dr. Mark D. Dollard DPM and his Staff to myself or my dependent/s**

____X____ **I authorize Dr. Dollard and his Staff to release information to my Health Insurance Carrier for payment of his services**

____X____ **I authorize Dr. Mark Dollard, Podiatrist and his staff to act as my agents in helping me obtain payment from my Health Insurance Carrier/s**

____X____ **I authorize payment by my Health Insurance or responsible party directly to Dr. Mark Dollard**

____X____ **I permit a copy of this Authorization to be used in place of the original**

____XX___ **I authorize payment for any outstanding balances due Dr. Mark Dollard to be billed and paid through my Credit Card Company. (Please circle and complete below)**

Credit Card : AMEX / VISA/ MSTRCARD : #____________________**Expiration Date**__________

Patient Name : ____________________________

I agree, that in the event collection of my account becomes necessary to pay all Attorney's Fees, Court Costs and/or Collection Fees.

Signature ____________________________ **Date** ________________