

Stockdale Podiatry Group, Inc.

MEDICINE AND SURGERY OF THE FOOT AND ANKLE

110 New Stine Road
Bakersfield, California 93309-2187
(661) 832-1666
Fax: (661) 832-7145

1326 H Street, Suite #1
Bakersfield, California 93301
(661) 826-1667
Fax: (661) 832-7145

REGISTRATION FORM

PATIENT'S NAME _____

ADDRESS _____ CITY _____ STATE _____

ZIP _____ PHONE () _____ SEX _____ DATE OF BIRTH ____ / ____ / ____

MARITAL STATUS (CIRCLE ONE) M S D O

SOCIAL SECURITY # _____ - _____ - _____ DRIVERS LICENSE # _____

WHO REFERRED YOU TO OUR OFFICE? _____

EMPLOYER _____ OCCUPATION _____

BUSINESS ADDRESS _____ ZIP _____ PHONE () _____ - _____

SPOUSE'S NAME _____ DATE OF BIRTH ____ / ____ / ____

EMPLOYER _____ OCCUPATION _____

BUSINESS ADDRESS _____ ZIP _____ PHONE () _____ - _____

SOCIAL SECURITY # _____ - _____ - _____ DRIVER'S LICENSE # _____

IN CASE OF EMERGENCY, CONTACT _____ RELATION _____

ADDRESS _____ ZIP _____ PHONE () _____ - _____

***** PLEASE PRESENT RECEPTIONIST WITH INSURANCE CARDS AND/OR CLAIM FORMS. *****

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED TO STOCKDALE PODIATRY GROUP, INC.

THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS AGREEMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

PATIENT'S SIGNATURE _____ DATE _____

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OFFICE POLICY

WELCOME TO OUR OFFICE

We find that communication with our patients regarding our financial policy assists us in providing the best of service to you. We therefore have taken the time to answer some of the most commonly asked questions.

PAYMENT AT THE TIME OF INITIAL VISIT

Payment is required at the time of the initial visit. Once benefits have been confirmed with your insurance company, we will collect any outstanding deductible, percentage, or co-payment amounts. Any financial arrangements must be made prior to treatment.

LAB FEES

Most insurance companies will pay for laboratory services. If it is necessary for us to order laboratory tests, you will be billed directly by them and responsible for payment of that bill.

REGARDING APPOINTMENTS

If you are unable to keep an appointment you have scheduled, we need at least 24 hours notice to allow another patient to use the time that has been set aside for your visit.

REGARDING INSURANCE

As a courtesy to our patients, we will bill your insurance company for you and withhold action for 6 weeks. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance company. Please advise us immediately if you are insured.

After receiving payments from your insurance company, we will bill you for any co-insurance, remaining deductible, or balance due on your account. If no payment is made within 60 days, a \$5.00 billing charge will be added to your account on each monthly statement.

NOTE

Our office charge for returned checks is \$25.00

PLEASE TURN OVER

SPECIAL NEEDS

Special needs are understood by us. It may be necessary to set up a payment plan for a patient requiring extensive treatment. If this situation is necessary for you, please bring the matter up as soon as possible.

COUPONS/COMPLEMENTARY EXAMS

Any coupons or complementary exams must be given to the receptionist prior to being treated.

WE ARE HERE TO HELP

Thank you for taking the time to read this policy statement, we hope that it answers any questions you have. If you have more to ask, please feel free to do so.

If you have any complications with your surgery or treatment, we ask you contact our office immediately for an appointment.

FINANCIAL POLICY REGARDING REFUNDS

It is our company's policy to issue refunds on credit balances that total \$20.00 or more, after 90 days of the last payment received. Credit balances less than \$20.00 may be applied towards future medical care services. However, for accounting purposes, we may adjust your balance to zero after six months of having a credit balance of less than \$20.00. This adjustment can be reapplied towards any medical services in the future.

As patient or legal guardian of a minor patient, I agree to pay all services rendered in accordance with the terms and conditions set forth in the Financial Policy of this office.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and request my Insurance Company to pay directly to Stockdale Podiatry, the amount due me for Medical Benefits under this claim.

DATE _____

SIGNATURE