BAYSHORE
Podiatry Center

508 S Habana Ave, Suite 230
Tampa, FL 33609

813.877.6636

Name: ______________________ **Nickname:** ____________

Sex: M / F **DOB:** ______________________ **Home #:** ____________

E-mail: ______________________ **Work #:** ____________

Address: ______________________ **Cell #:** ____________

City: ____________ **State:** ________ **Zip:** ____________ **PCP Phone:** ____________

Primary Care Physician: ______________________ **PCP Last Seen Date:** ____________

PCP Address: ______________________

Primary language: ☐ English ☐ Spanish ☐ Other: ____________

Race *(optional)*: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ American Indian/Alaska native ☐ Native Hawaiian/Pacific Islander

Spouse/Parent Name: ______________________ **Pharmacy:** ____________

Phone Number: ______________________

Marital Status: ☐ single ☐ married ☐ widowed ☐ divorced **Pharmacy Phone #:** ____________

Pharmacy Address: ______________________

Employer/School: ______________________

Address: ______________________ **Employer/School Phone #:**

Current medications prescribed by a doctor or over-the-counter: ______________________

Allergies: ______________________

Shoe size: ____________ **Height** ____________ **Weight** ____________

What type of shoes do you wear most often? ______________________

What shoes (if any) do you wear at home? ______________________

What is the reason for your visit today? ______________________

How long has this bothered you? **Days / Weeks / Months / Longer**

What treatments have you tried & have they been efficient? ______________________

HOW DID YOU HEAR ABOUT US?

☐ Physician(Dr.?) ____________

☐ Family/Friend ____________

☐ Other ____________

☐ Health Fair/Event (which one?) ____________

☐ Other Website (which one?) ____________

☐ Google

☐ Our website

☐ Local Hospital

☐ Facebook

☐ Yelp

Check out our page and like us on Instagram!

Visit us online at www.bayshorepodiatry.com

Revised 08/2024

Assignment of Benefits & Authorization to Release Information

If I am entitled to benefits under any insurance policy, Medicare, or other health benefit plan (covering me or anyone legally responsible for me), in consideration for services provided to me by Bayshore Podiatry Center. 1 assign, transfer and convey the benefits payable under such program, policy or plan for services rendered to me. I authorize payment of benefits directly to Bayshore Podiatry Center, with such benefits to be applied to my bill. **I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts, deductibles, Durable Medical Equipment, and any charges for services deemed to be non-covered, not pre-certified, or not pre-authorized by my insurance.**

_______ *(initial)* I give my consent for examination and treatment by Bayshore Podiatry Center.

Responsible Party Signature: ______________________________

Relationship: ______________________________ Date: ______________

NOTICE OF PRIVACY PRACTICES AND DESIGNATION

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient: ______________________________ Date of Birth: __________

Signature of Patient/Parent/Guardian ______________________________ Date: _______

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Name: ______________________________ Last four digits of SSN or other identifier: ______________

Name: ______________________________ Last four digits of SSN or other identifier: ______________

Emergency Contact: ______________________________ Emergency Contact Phone Number: ______________

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number: __________________ Written Communication Address:__________________________

____

_____ OK to leave message with detailed information.

_____ Leave message with call back numbers only.

Cell Phone Number: __________________

___ OK to leave message with detailed information.

___ Leave message with callback number only.

______ OK to mail to address listed above

______ OK to email at address on file.

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION

1. The preceding authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive healthcare at the Practice.

2. These Authorizations may be revoked at any time by notifying the Practice in writing at the Practices mailing address marked to the attention of "HIPAA Compliance Officer."

3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

4. I may see and copy the information described in this form, if I ask for it, and I will get a copy of this form after I sign it.

5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy if one was requested.

6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

______________________________	______________________________	__________
Name of Patient (Printed)	Signature of Patient	Date

E-PRESCRIBING CONSENT FORM

ePrescribing is defined by a Physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:

- Formulary and benefit transactions - gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

I authorize Bayshore Podiatry Center to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at Bayshore Podiatry Center, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Bayshore Podiatry Center medical record.

Understanding all of the above, I hereby provide informed consent to Bayshore Podiatry Center to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

This consent will remain enforce until revoked or changed.

____

Patient Name (PLEASE PRINT)

______________________________________	______________
Signature	Date

BAYSHORE
Podiatry Center

We at Bayshore Podiatry Center are committed to providing you with the best possible care. If you have Medical Insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding on our payment policy.

Unless INSURANCE ARRANGEMENTS have been approved in advance by our staff, payment for services is due at the time services are rendered. We accept payment in the form of cash, check, MasterCard, American Express, Discover, or Visa. We will be happy to help you process your insurance claim at each visit.

Returned checks and balances older than 30 days are subject to additional collection fees and interest of 1.5% per month. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Insurance is a contract between you and your insurance company.

2. Our fees generally fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R.. "U.C.R." is defined as Usual, Customary and Reasonable fees for this region. Thus, our fees are considered Usual, Customary, and Reasonable by most companies. This does not apply to companies who reimburse based on arbitrary "schedule" of fees, which bears no relationship to the current standard of fees and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily refuse to cover certain services. We have no control over this.

4. **MEDICARE PATIENTS**: We would like you to understand that accepting assignment means that YOU are responsible for the YEARLY DEDUCTIBLE and for the 20% (co-insurance) of what Medicare allows. You are also responsible for services that your supplemental/secondary insurance does not cover. If your supplemental/secondary insurance does not pay this amount, YOU are responsible for it.

The filing of insurance claims is a courtesy that we have always extended to our patients. However, all charges are your responsibility, not your Insurance Company's. We will make our best effort to collect from them, but if, despite our best efforts, we are not successful, you are responsible for the unpaid balance.

We realize that temporary financial problems may affect timely payment of your account. We don't want any financial problems to get in the way of our good relationship with you. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you.

1. **INSURANCE:** We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **PATIENT BILLING**: All co-payments, co-insurance, or deductible amounts must be paid 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 portion of insurance benefits at each visit. Postdated checks are not accepted. Co-insurance and unmet deductibles are due prior to scheduled surgeries and procedures. Once benefits are verified and your financial responsibility calculated, you will be notified of the payment amount and due date.

3. **SELF PAY**: Payment in full is due at the time of service if you do not have health insurance. You are ultimately responsible for payment of charges for services you receive from our office.

4. **REFERRALS/AUTHORIZATIONS**: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician **prior** to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. You will also be given the option to reschedule your appointment.

5. **CANCELLED/MISSED APPOINTMENT FEE:** If you cannot keep your appointment time, please call our office at least 24 hours prior to your scheduled appointment time. There may be a $50 fee for any appointment canceled or rescheduled within 24 hours of the scheduled time. Additionally, there may be a $50 fee if you miss a scheduled appointment. If you miss 3 or more appointments, you may be required to pay a $50 deposit to hold any future appointment time slots. If you arrive late for an appointment, we may need to reschedule your appointment. You will bear complete financial responsibility for any fee(s) incurred. Repeated missed or late appointments may result in dismissal from our practice. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date and time.

6. Payment is due for rendered services at the time of service. Unpaid previous balances must be paid in full prior to any additional visits, unless arrangements have been made with our financial counselor. An additional $35.00 will be added to your statement if the check is returned from your bank.

7. **COLLECTIONS FEE:** You will be sent up to three notices for your financial responsibility (co-insurance, deductible. etc.) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. There will be a $10 re-billing fee acquired on your third notice. After the third and last notice, your account will be forwarded to our collection agency. If your account is sent to a collections agency, a 35% fee will be added to your account. You bear complete financial responsibility for any fee(s) incurred.

8. **PHYSICIAN PHONE CALLS**: Phone calls with our physician(s) are a billable service, may be billed to your insurance company/companies, and are subject to your insurance benefits. You are responsible for your portion of insurance benefits for physician phone calls.

9. Medical records requests must be received in writing. Fees for medical records are set in accordance with allowable amounts as defined by the state of Florida. Fees must be received prior to record delivery. No more than 5 pages may be faxed. Please allow 5 business days for medical record retrieval.

10. **ADMINISTRATIVE SERVICES:**There is a $25.00 charge for each Administrative Service payable prior to service completion. This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability, letters for insurance authorization for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative item not covered by insurance.

11. **NON-CUSTOM DURABLE MEDICAL EQUIPMENT RETURNS**: If a patient is unsatisfied with any non-custom Durable Medical Equipment item, it must be returned within 30 days per Medicare guidelines. Returns after 30 days will not be permitted. The item will only be accepted as a return if it is in returnable condition. Any custom durable medical equipment item may not be returned for any reason. Any over the counter item purchased at the time of service is non-refundable; all sales on these products are final.

12. **PATIENT REFUNDS**: Please allow 60 days from the time your insurance company responds to a claim for your deposit refund to be processed. Refunds will be issued in the form of a paper check that will be mailed to your home address.

13. **E-MAIL COMMUNICATIONS:** By providing your email address and signing below, you consent to receive electronic communications related to your medical care, such as appointment reminders, treatment information, follow-up instructions, and marketing. Please note that we cannot transmit any HIPAA sensitive information via email. Your information will be handled in compliance with HIPAA and Florida state privacy laws to ensure your confidentiality.

I,______________________________________, have received, read, and understand the financial policy at Bayshore Podiatry Center.

____

Signature of Patient/Guardian

____

Date