Hoyal Podiatry

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Other family members seen here, if any:

I heard about Hoyal Podiatry from:
❑ Doctor ❑ Insurance ❑ Hospital ❑ Family ❑ Friend ❑Drive-by ❑ Yellow Pages ❑ Other______________________

If referred by someone, please write name here so we can thank them!

Legal name: First Middle Last	**Preferred name**	**Marital status** (circle one) Single / Mar / Div / Sep / Wid

Date of Birth / /	**Gender** ❑ M ❑ F	**Social security number**	**Email**

Street address City State Zip code

I prefer my appointments to be confirmed by:
❑ Call ❑ Email ❑ Text to cell#_______________

Race (circle one):
White Asian Black/AfricanAmerican Multi-Race PacificIslander
AmericanIndian/AlaskaNative NativeHawaiian Refuse to Report

Ethnicity (circle one):
Hispanic/Latino Non-Hispanic/Latino Refuse to Report

Phone numbers:
My preferred # is: (circle one) Cell Home Work

Cell:

Home:

Work:

RESPONSIBLE PARTY AND INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Phone Number:

Relationship to patient:

Is patient covered by insurance? ❑ Yes ❑ No

Name of **primary** insurance:

Subscriber's name:	Birth date: / /	Policy number:	Insurance phone #:	Insurance address:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of **secondary** insurance (if applicable):

Subscriber's name:	Birth date: / /	Policy number:	Insurance phone #:	Insurance address:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Phone number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Hoyal Podiatry or insurance company to release any information required to process my claims.

Patient/Responsible Party signature

Date

Podiatry Registration and History

Patient Name____________________________ **Date**______________ **Preferred Pharmacy**_______________

Podiatric History

What problem are we seeing you for today?____

How long have you noticed this problem?__________________ Approximate Date of Injury?_________________

List previous treatments for this problem:____

Have you ever seen a Podiatrist before? Y N For what problem?___________________________________

Medical History

Height_________ Weight___________ Do you Smoke? Packs per day:________________

Age___________ Shoe Size_________ Do you drink Alcohol? How often?_____________

Review of Systems: If you have problems with any of the following health conditions, please circle them.

Anemia	Dementia or Memory Loss	High cholesterol	Stroke
Arthritis	Depression	Infection (currently)	Swelling in ankles/feet
Artificial Heart Valves	Diabetes(Type I or Type II?)	Kidney problems	Thyroid problems
Artificial Joints	Eye problems	Liver Disease	Tuberculosis
Asthma	Fibromyalgia	Low blood pressure	Ulcers (stomach)
Back problems	Foot/leg cramps	MS	Ulcers (leg/foot)
Bleeding Disorders	Gout	Neuropathy	Varicose veins
Cancer	Heart Disease	Phlebitis	
Chest Pain	Hepatitis/Jaundice	Psychiatric Care	Other:___________
Circulatory Problems	High blood pressure	Respiratory Disease	

Allergies?

Please circle if allergic:

Adhesives,Tape
Codeine
Coumadin/Warfarin
Demerol/Meperidine
Iodine
Local Anesthetic
Penicillin
Sulfa
Shellfish
Vicodin/Hydrocodone
Other:___________

Medications (Include prescriptions, over-the-counter medications, and vitamins)

Medication Name	*Dosage/Strength (i.e. 20mg)*	*How often do you take this?*

Major surgeries you have had:____

Other Hospitalizations:____

Primary Care Doctor____ Date Last Seen__________________

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐No

If yes, please explain____

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet with my consent.

Patient/Responsible Party Signature____ **Date**________________

Policies and Procedures Agreement

HIPAA PRIVACY POLICY

I have received or been offered a copy of James I Hoyal, DPM's Notice of Privacy Practices. I understand that my information will be used for the purpose of treatment, payment, and healthcare operations as described within.

MEDICAL TREATMENT POLICIES

I understand that X-ray originals are owned by the doctor as they are a part of the medical record. I may receive a digital copy at my request.

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the care of the patient with my consent. I understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor or staff. I authorize the doctor to retrieve a list of my current medications in order to check for any possible interactions with my treatment.

INSURANCE GUIDELINES

I understand that my insurance policy is a contract between myself and my insurance carrier. The medical office is a third party that bills the insurance as a courtesy to me. Due to the large number of different insurance companies and their frequent changes, it is very difficult to keep track of each insurance plan's ever-changing benefits and rules. While the medical staff will do their best to assist with insurance matters, I understand that it is ultimately my responsibility to know what my insurance covers. The doctor will assess and offer treatment based on the best medical options available, but if I have a question about coverage I have the responsibility to contact the insurance before accepting treatment.

It is my responsibility to understand the terms of my contract with my insurance company in regard to copays, deductibles, and benefit amounts. Copays and deductibles will be collected at the time of service from the medical office. If my insurance company is delinquent on paying for my treatment, the medical office may request payment from me and will refund me once the insurance pays. If my insurance requires a referral it is my responsibility to obtain that before date of service.

FINANCIAL AGREEMENT

Missed appointments and same-day cancellations may be subject to a $25 charge. Because my appointment time is reserved specifically for me, it is my responsibility to give 24 hours notice if I will not be able to keep my appointment.

By signing below I agree to pay all amounts owed within 30 days of when such amounts are incurred. If I am unable to pay the full balance on my account, I will make payments each month toward the balance until it is paid off. If no payment is received within 30 days my account will accrue interest at a rate of 1.5% of the remaining principal balance each month. Any balance that has no payment made for 90 days will be sent to a debt collections agency. The medical office will attempt to contact me both by phone and mail before this happens. In the event the account is turned over to Collections, I understand that I am responsible for all court costs and a collection fee of up to 40% of the principal balance as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this agreement apply to any present or future expenses incurred by me or by any individual for whom I have financial responsibility.

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Patient/Responsible Party Signature *Date*