



# Foot Specialists of Birmingham, P.C.

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## Patient Information

Date: \_\_\_\_\_  
Patient: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Marital Status:  Married  Single  Divorced  
 Widowed  Partnered  Minor  
Parents Name (if Minor) \_\_\_\_\_  
Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

## Insurance Information

**Primary Insurance:** \_\_\_\_\_  
Policy Holder's Relationship: \_\_\_\_\_  
Social Security # of Policy Holder: \_\_\_\_\_  
D.O.B. of Policy Holder: \_\_\_\_\_  
**Secondary Insurance:** \_\_\_\_\_  
Policy Holder's Relationship: \_\_\_\_\_  
Social Security # of Policy Holder: \_\_\_\_\_  
D.O.B. of Policy Holder: \_\_\_\_\_

## Family Medical History:

*Please check if anyone in your family has had any of the following*

Diabetes  Heart Disease  
 Gout  Bleeding Disorder  
 Rheumatoid Arthritis  
 Peripheral Vascular Disease (PVD)

Other: \_\_\_\_\_

**Referred By:**  Physician: \_\_\_\_\_

Internet  Phone Book  Friend  Other

## Social History

Do you smoke?  Y  N  
Do you drink alcohol?  Y  N  
Do you use recreational drugs?  Y  N  
Do you exercise regularly:  Y  N

## Allergies

Adhesive Tape  Local Anesthetics  
 Aspirin  Lortab  
 Codeine  Penicillin  
 Demerol  Seafood  
 Iodine  Sulfa  
 Latex  No Allergies  
Other \_\_\_\_\_

## Surgical History

Appendectomy  
 Gall Bladder  
 Hysterectomy  
 Foot/Ankle Surgery  
 C-Section  
 Heart  
 Eye  
 Thyroidectomy  
 Tonsillectomy  
 Knee  
 Back

Other \_\_\_\_\_



**PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION  
CONSENT AND ACKNOWLEDGEMENT**

(PLEASE PRINT)

Patient Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address \_\_\_\_\_ SSN: \_\_\_\_\_

\_\_\_\_\_

I give Foot Specialists of Birmingham, P.C. permission to release medical information to the follow persons:

- None
- Parents \_\_\_\_\_  Spouse \_\_\_\_\_
- Father (only) \_\_\_\_\_  Mother (only) \_\_\_\_\_
- Other \_\_\_\_\_  Guardian \_\_\_\_\_

I wish to be contacted in the following manner by Foot Specialists of Birmingham, P.C. (check all that apply):

- Home Telephone** \_\_\_\_\_  **Written Communication**
  - O.K. to leave message with detailed information  O.K. to mail or Email to my home address
  - Leave message with call back number only  O.K. to mail or Email to my work/office
  - O.K. to fax to this number \_\_\_\_\_
- Work Telephone** \_\_\_\_\_  Other (Email address) \_\_\_\_\_
  - O.K. to leave with detailed information
  - Leave message with call back number only

The Privacy Act generally requires healthcare providers to take responsible steps to limit the use of disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record.

**CONSENT:**

I consent to the use and disclosure of protected health information about me by my physician and my physician's practice for purposes of treatment, payment, health care operations, protection of others and disclosures required by law, including information about notifiable diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV).

NOTE: Uses and disclosures for protected health information may be permitted without consent in an emergency.

**ACKNOWLEDGEMENTS:**

I acknowledge that I have received Foot Specialists of Birmingham, P.C. Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Personal Representative to the Patient

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Print personal Representative's Name

## FINANCIAL POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

**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 do 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.

**MEDICARE:** We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any co-payments, which are usually 20% of the allowed amount for an item or service.

**SECONDARY INSURANCE:** Your medical claim will be forwarded to your secondary insurance (if any except for Medicaid, because Medicaid does not pay for podiatry in the State of Alabama) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

**CO-PAYMENTS AND DEDUCTIBLES:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

**SELF-PAY ACCOUNTS:** Payment in full is due at the time of service if you do not have health insurance.

**NON-COVERED SERVICES:** Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payments of these services.

**REFERRALS/AUTHORIZATIONS:** We are required to follow the guidelines of your managed care plan which mandates that when you visit a specialist such as ours, you must have a referral form your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for services received, unless your referral is presented at the time of the 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 provided to you or you can reschedule your appointment.

**CLAIM 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.

**PATIENT BILLING:** You will be sent up to three (3) notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and final notice, your account may be forwarded to collections. All cost incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payments methods: Cash, Check, and VISA/MasterCard. An additional \$30.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

**I have read the above policy regarding my financial responsibility to Foot Specialists of Birmingham, P.C. for medical services provided. I agree to pay Foot Specialists of Birmingham, P.C. any balance unpaid by my insurance carrier for myself or the below named person.**

**ASSIGNMENT OF BENEFITS:**

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Foot Specialists of Birmingham, P.C.** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurances, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

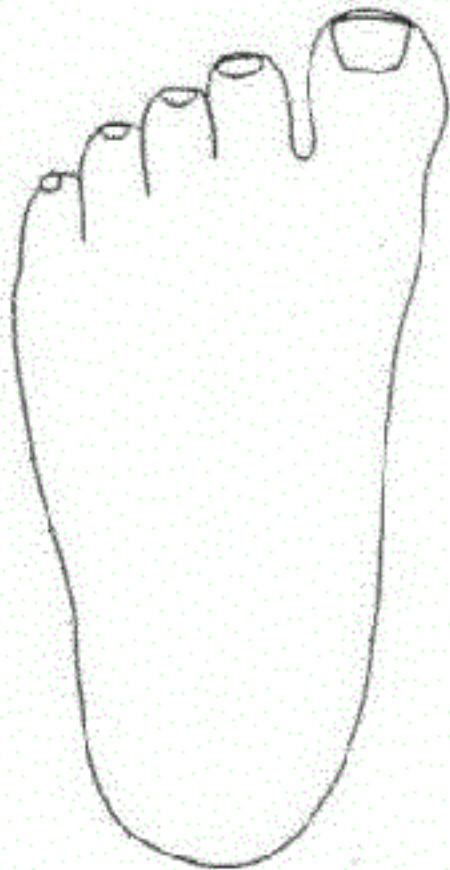
**FINANCIALLY RESPONSIBLE PARTY:**

Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_



PLEASE MARK WHERE YOU ARE EXPERIENCING PAIN

Left Foot (top)



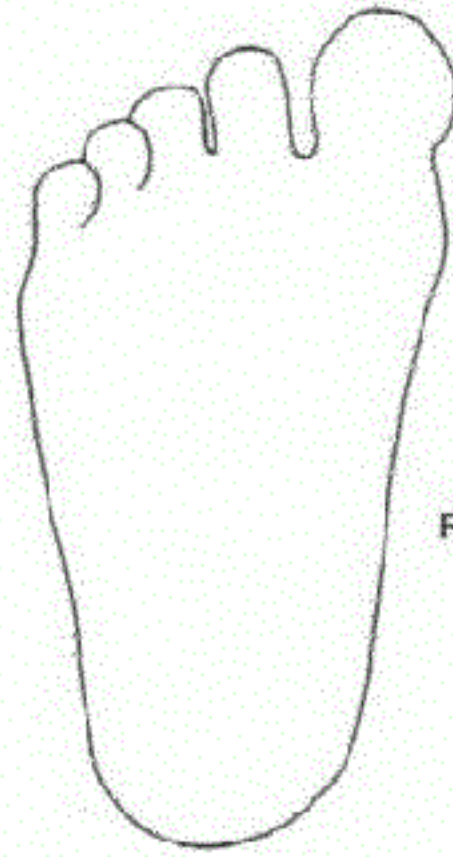
Right Foot (top)



Left Foot (bottom)



Right Foot (bottom)



INITIAL \_\_\_\_\_

DATE \_\_\_\_\_