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| **PATIENT INFORMATION TODAYS DATE:** **NAME: DOB: / / SEX: M/F****First M.I. Last Mo Day Year****Social Security# Marital Status:** **EMAIL ADDRESS: (Information is for OUR USE ONLY)****Mailing Address: Home #**  **Cell # Employer: Work # EMERGENCY CONTACT (MUST HAVE): Relation:** **Daytime PH#: Evening#: Cell#:**  |
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| **INSURANCE INFORMATION:****Primary Insurance Carrier: Tel #: ID #: GRP #: Subscriber:**  **Subscriber DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Secondary Insurance Carrier: Tel #:** **ID #: GRP #: Subscriber:** **Subscriber DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Does patient have any other insurance?: Yes / No If yes, please put Name, Address, Tele#, Policy ID#, and GRP # on the back of this form |
| **SPOUSE INFORMATION:****NAME: DOB: / / SEX: M/F****First M.I. Last Mo Day Year****Employer: Work # Cell#: Do you live at the same address as the patient?: Yes / No If NO, please complete below:****Address: Home:#**  |
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| **SIGNATURE ON FILE:**I AUTHORIZE (1) Use of my signature on all my insurance submissions,(2)Release of info to all my insurance companies,(3)My doctor to act as my agent in helping me obtain payment from my insurance carrier,(4)Payment made directly to Podiatry Centers of Maryland (Capitol Cardiology Assoc),(5)Permit a copy of this authorization to be used in place of the original, and(6)I understand that I AM RESPONSIBLE FOR MY BILL.**PRINT Name: Medicare #:** **(If applies)****SIGNATURE: DATE:**  |

**AUTHORIZATION AND CONSENT TO TREATMENT**

**CONSENT TO TREATMENT:** As a Podiatry centers of Maryland Patient, I voluntarily consent to the rendering of care and treatment at Podiatry Centers of Maryland (Capitol Cardiology Associates).

If I request or initiate a telehealth visit (a ‘virtual visit’), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing, including but not limited to, minor surgical procedures and vaccine administration. My consent shall cover the carrying out of the orders of my treating provider by office personnel.

**ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION:** I hereby certify that the insurance information that I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any services furnished to me by Podiatry Centers of Maryland (Capitol Cardiology Associates). I authorize Podiatry Centers of Maryland (Capitol Cardiology Associates) to file an appeal on my behalf for any denial of payment. If my health insurance plan or carrier pays me for the services rendered at Podiatry Centers of Maryland (Capitol Cardiology Associates),

 I agree to forward in full all health insurance payments to Podiatry Centers of Maryland (Capitol Cardiology Associates). I authorize Podiatry Centers of Maryland (Capitol Cardiology Associates) to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services.

**GUARANTEE OF PAYMENT:** In consideration of the services provided by Podiatry Centers of Maryland (Capitol Cardiology Associates), I agree that I am responsible for all charges for services provided not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan.

**CONSENT TO CALL, EMAIL, TEXT**: I understand and agree that Podiatry Centers of Maryland (Capitol Cardiology Associates) may contact me using automated calls, emails and/or text messages sent my landline and/or mobile devices. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communication from Podiatry Centers of Maryland (Capitol Cardiology Associates).

**HIPAA:** I understand that a copy of Podiatry Centers of Maryland (Capitol Cardiology Associates) Privacy Notice is available, and I may request a paper copy with Podiatry Centers of Maryland (Capitol Cardiology Associates) receptionist.

**If you want us to speak to another person about your health issues, please list their name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name:(printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**We require that all patients sign our Authorization and Consent to Treatment Form before receiving medical services. This form confirms that you understand that the services provided are necessary and appropriate and advises you of your financial responsibility with respect to services rendered.**

**FINANCIAL POLICY**

Welcome to Podiatry Centers of Maryland (Capitol Cardiology Associates). Our mission is to provide you with the highest level of professional medical care with the highest degree of patient satisfaction.

**INSURANCE**

We accept assignment of benefits; we will submit charges for services rendered to your insurance carrier on your behalf. You are expected to pay the entire amount determined by your insurance to be the patient responsibility.

**It is the patient’s responsibility to provide referrals and making sure if an authorization is necessary for your procedures.** You must also make certain that you have coordinated your benefits if you have more than one insurance plan. You may be required to contact your insurance company to clarify which plan is primary or secondary. Paying deductibles, copays, co-insurance and non-covered services are your responsibility.

**PATIENT RESPONSIBILTY**

Patients or their legal representatives are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance.

**OUTSTANDING BALANCES**

After your visit, we will send you a statement for any outstanding balances after your insurance paid their portion. All outstanding balances are due on receipt.

**MISSED/ NO-SHOWS APPOITMENTS**

If you miss your appointment, a $25.00 No-show fee will be charged to your account. Diagnostic Testing fees are different and are outlined at the time when your procedure is scheduled.

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**