Glen N. Robison DPM, P.L.C.
Patient Demographic Information Sheet
(Please Print)

SS: ____-__-_____ **Patients Name:** _____
(Last Name, First Name, Middle Initial)

Mailing Address: _____ City:_____ State:_____ Zip Code:_____

Home Address: _____ City:_____ State:_____ Zip Code:_____

Date of Birth: ___/___/___ Sex :(Male / Female) Martial Status :(S / M/ D / W)
Month/ day/ year

Phone: (___) ___-_____ **Other Phone:** (____) ____-____ **Email Address:** _____

Primary Care Physician: _____ **PCP Phone :**(___) ____-____ **Fax:** (___) ___-___

Patient Employer: _____ **Work Phone:** (____) ____-_____

Primary Insurance:
Name of Insurance: _____
Policy: _____ Group:_____
Insured's D.O.B_____ Male / Female
Insured's Employer:_____
Insured's Name :_____
Insured's Social Security #____-____-____

Secondary Insurance:
Name Of Insurance: _____
Policy:_____ Group:_____
Insured's D.O.B_____ Male / Female
Insured's Employer:_____
Insured's Name:_____
Insured's Social Security #____-____-_____

Who May Receive information regarding your protected Health Information?

Name: _____ Date of Birth:___/___/___ Relationship: _____
Name: _____ Date of Birth:___/___/___ Relationship: _____

What is the best way to reach you regarding future appointments?
Phone _____ Email_____ Text message_____

May we leave messages regarding test results and appointments on your voicemail or answering machine?
Yes or No

I have received a copy of the Privacy Rules from this provider and authorized the above listed person who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

Date: _____ **Signature:** _____
Circle One (Patient / Parent? Legal Guardian)

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GLEN N. ROBISON DPM

A. Notifier: Dr. Robison

B. Patient Name: **C. Identification Number:(Dob)**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D. See Below** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
	POSSIBLE NON-COVERED SERVICES DUE TO CHANGES IN MEDICARE COVERAGE	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. See Above :** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

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MEDICAL HISTORY

Patient Name:_____ Age_____ Today Date_____
Name of Primary Care Physician Dr. _____ Has he / she request you be seen in our office Yes No
Women only -- Are you Pregnant ? Yes No If so, how many months? _____

HISTORY OF PRESENT ILLNESS

What is your FOOT or ANKLE Pain / problem? Please Be specific

_____

_____

Location of Pain/Problem _____
Severity of Pain? 0 1 2 3 4 5 6 7 8 9 10 (On a scale of 1-10) (Please Circle)
Prior Treatments ☐ yes ☐ no _____
How long have you had the Pain/Problem_____ When did it start_____
Is the Pain sharp dull stabbing burning superficial deep other_____ (Please circle)
What makes the pain or discomfort feel better_____ feels worse _____

PAST MEDICAL HISTORY

LIST **DRUG ALLERGIES** AND HOW THEY AFFECT YOU (If you have a list please check here) ☐

1._____/_____ 2._____/_____ 3._____/_____

LIST **CURRENT MEDICATION** (If you have an photo copy of Medications please check here) ☐

1._____ 4._____ 7._____
2._____ 5._____ 8._____
3._____ 6._____ 9._____

LIST **PREVIOUS SURGERY** (Please indicate date, type and any complications)

1._____ 3._____ 5._____
2._____ 4._____ 6._____

Hospitalization (non Surgical): _____
Date of last Physical _____/_____/____ **Chest x-rays** _____ **EKG** _____ **Tetanus Shot** _____
If you have the following, or have had, please circle:

Anemia	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Back injury	Yes	No
Bleeding Tendencies	Yes	No
Congestive Heart Failure	Yes	No
Deep Vein Thrombosis	Yes	No
Diabetic	Yes	No
Heart Attack	Yes	No
Heart Disease	Yes	No
Hepatitis	Yes	No
HIV/AIDS	Yes	No
Hypertension	Yes	No
Mitral Valve Prolapse	Yes	No
Murmur	Yes	No
Stomach /Bowel Problem	Yes	No
Stroke	Yes	No
Serious injury	Yes	No
Gout	Yes	No

Have you ever had a blood transfusion? **Yes No**

FAMILY HISTORY: Who in your family has/had?

Cancer _____
Diabetic _____
Foot Problems _____
Heart Disease _____
High Blood Pressure _____
Stroke _____
Other family related Medial Conditions:
_____

SOCIAL HISTORY

Do you Smoke Now? Yes No
How many Packs a Day? ____ For how Long ____
Would you Like to Quit Yes No
Have you Ever Smoked? Yes No
When did you Quit? _____
Do you Drink Alcohol? Yes No Type _____
☐ Daily ☐ Rarely ☐ Socially ☐ Moderate
Do you use Recreational Drugs? Yes No.
Are you over Weight? Yes No
If Yes by how much _____
Your Average Weight _____ Your Current Weight _____
Height _____ Shoe Size _____

In the space below, please indicate any other medical problems you have not listed on this form:

FINANCIAL POLICY DR. GLEN N. ROBISON

MEDICARE PATIENTS

This office accepts Medicare assignment. Medicare assignment means that we accept as full payment the amount that Medicare approves. Medicare then pay 80% of its' allowable fee, after you have met your required deductible, which at this time is $100.0, per calendar year. The patient is then responsible for the 20%, of the approved amount, that Medicare did not pay. The balance of the 20% is the responsibility of the patient either through payment from their supplemental insurance or direct payment form the patient. **It is your responsibility to know and confirm your benefits before receiving treatment.**. You will receive an explanation of Medicare benefits direct from Medicare, showing what was allowed and paid by them and what will be your responsibility. You will also receive a statement from our office if there is a balance due, direct, from you, the patient. Certain Services particularly routine foot care and Orthotics are not covered by Medicare and patients are responsible for 100% of these charges. You will be notified, in advance of any treatment or service that is not covered by Medicare. **You have the right to be informed of, and refuse any treatment recommended by the Doctor**.

CASH PATIENTS

As with all professional services, payment is normally expected at the time that services are rendered. We will be happy to provide you with an estimate of any services, prior to providing the service. It is our policy, in this office, that no one is denied medical care, because of an inability to pay. We will make every effort to work out a payment arrangement that is feasible to you and to our office. **You have the right to be informed of, and refuse any treatment recommended by the Doctor.**

PRIVATE INSURANCE PATIENTS

Your insurance policy is a contract between you and your insurance company. **It is your responsibility to know and confirm your benefits before receiving treatment. You have the right to be informed of, and refuse any treatment recommended by the Doctor. We cannot guarantee payment of your claim.** If it is not paid, the insurance company should send you an explanation of benefits to explain why it was denied. **We do look to you for final payment.**

As a courtesy to you, our office will bill your primary and secondary insurance carrier for you. You, however, are ultimately responsible for the entire balance. If we are billing your insurance for you, it is extremely important that you furnish us with your most current insurance information. This will ensure that our information is accurate and that your claim will be filed, in a timely fashion, by our office. You will be asked to sign a Assignment of Benefits. This assignment provides for the payment of benefits directly to us, for the services billed.

If we are billing your insurance, we will set aside the portion of the balance, estimated to be paid, by your insurance carrier, for sixty (60) days. We require that your co-pay and deductibles be paid at the time of your visit. If your insurance carrier does not remit payment with (60) days, we have the prerogative to request the full balance from you.

Since we are not a party to the agreement with your insurance carrier (other then "Participating" HMO, PPO, IPA and government plans) it is not our policy to contact carriers to establish why they haven't paid or why they paid less than originally indicated. If a payment is, subsequently, made by your insurance carrier, in excess of the balance, we estimate, we will promptly credit your account and/or refund you this amount, per a written request.

If you anticipate a large bill or are having financial difficulties, it is important that you contact our billing Service, They can make payment arrangements, if they are aware that there is a problem.

"You Can Contact MEDSTAT inc. at 1-800-794-3319"

***** **Accounts over 120 days past due may be turned over to an outside collection agency. Any fees incurred by our office associated with collection on a past due account, including administrative or legal costs, will be the patients responsibility. A fee of 33 1/3 % to 50% will be added to unpaid balances that require collection and / or legal services**

Patient Signature: _____ Date : _____

(Parent or legal Guardian if Minor)