The Foot Performance Center, Inc.

Name: _____ _____ Date: ____/____/____
FIRST NAME LAST NAME

_____**Male** _____**Female** _____**Married** _____**Single** _____**Other**

Street Address: _____

City / State /: _____ Zip Code: _____

Primary Phone: (_____) _____-_____ Secondary Phone: (_____) _____-_____

Other Phone: (_____) _____-_____ E-mail: _____

*Birth Date: _____/_____/_____ Do you have diabetes? Yes _____ No _____ _____

Contact Person **(If other than patient):** _____ Ph.: (____) _____-_____

PRESCRIBING DOCTOR:
PRESCRIBING DOCTOR LOCATION:
PRIMARY CARE DOCTOR:
PRIMARY CARE DOCTOR LOCATION:
ENDOCRINOLOGIST:

Primary Medical Insurance: _____ Policy #_____
NUMBER MUST INCLUDE 2 DIGIT SUFFIX

Subscriber's Name: _____ Relationship to Patient: _____
(IF DIFFERENT THAN PATIENT)

Subscriber's DOB: ____/____/____

Secondary Medical Insurance:_____ Policy #_____
NUMBER MUST INCLUDE 2 DIGIT SUFFIX

The Foot Performance Center, Inc. provides patients and customers with prescription and non-prescription Orthotic & Pedorthic services. A Board Certified Pedorthist or Orthotist will review your doctor's instructions and dispense, fit and maintain the prescribed item(s).

Our financial policy agreement will be given to you for your review after your physician order and our practitioner evaluation is completed. You will have the option to proceed or not to proceed with the treatment plan.

I UNDERSTAND THAT VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF COVERAGE. ACTUAL COVERAGE IS DETERMINED AT THE TIME THE CLAIM IS RECEIVED BY THE INSURANCE PROVIDER. I AM RESPONSIBLE FOR PAYMENT OF THE SERVICES PROVIDED TO ME IF MY INSURANCE COMPANY DENIES COVERAGE.

I understand and agree that because of human variance and response, it is not possible to guarantee the outcome of any care or service provided by The Foot Performance Center, Inc. or its employees.

Assignment & Release: I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of insurance benefits either to myself or to the party who accepts assignment on my claims.

Signature: _____ **Date:** ____/____/____
If under 18 a responsible party signature required

The Foot Performance Center, Inc.
3385 Brighton Henrietta Town Line Road
Rochester, New York 14623
(585) 473-5950

Information Access Authorization

I, _____, herby grant authorization to the following persons (*family members/friends*) to have access to my personal health information. I grant these persons access to all information and grant them the power to make decisions on my behalf. I understand that this access may be changed or revoked by at any time. This must be done in writing and sent to this office, Attn: Dan Sherwood, HIPAA Compliance Officer.

Authorized Person(s) Excluding Physicians:

Name: _____ Phone: _____

Name: _____ Phone: _____

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received or been offered my *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. ***(THIS FORM IS AVAILABLE AT THE FRONT DESK)***

I also understand that in the event of any medical emergency, The Foot Performance Center will contact the individuals I have listed above. If I am unresponsive/unconscious, the Foot Performance Center will contact NYS Emergency Services **(911).** In the event that I am responsive/conscious AND medically cleared by a paramedic, I reserve the right to refuse treatment but am highly recommended to seek medical treatment by a physician.

Patient Name: (print) _____

Signature: _____

Relationship to Patient: _____

Date: _____