Dr. Mark E. Spier

Diplomate, American Board of Podiatric Surgery
Podiatry, Foot Surgery, Sports Medicine

Patient Information & Health Record

In order to help us render the proper podiatric services to you, please complete this form entirely.
We thank you for your cooperation.

PATIENT NAME________________________________ **MARITAL STATUS**__________ **SEX**______

DOB____/______/______ **AGE**______ **EMAIL ADDRESS**________________________________

ADDRESS______________________________ **CITY**__________ **STATE**________ **ZIP**__________

HOME PHONE______________ **WORK PHONE**______________ **CELLPHONE**______________

EMPLOYER________________ **OCCUPATION**______________ **PHARMACY**______________

PHYSICIAN______________ **PHONE NUMBER**______________ **PHARMACY #**______________

INSURANCE INFORMATION

PRIMARY INSURANCE
NAME____

ADDRESS______________________________ **POLICY #**______________________

GROUP#__________ **SUBSCRIBER NAME**____________________ **DATE OF BIRTH**____/____/______

SUBSCRIBER EMPLOYER____

SECONDARY INSURANCE
NAME____

ADDRESS______________________________ **POLICY #**______________________

GROUP #__________ **SUBSCRIBER NAME**____________________ **DATE OF BIRTH**____/____/______

SUBSCRIBER EMPLOYER____

HOW DID YOU HEAR ABOUT OUR OFFICE? ☐**INTERNET/GOOGLE** ☐**DR**__________ ☐**OTHER**________________

HEALTH INFORMATION

Have you ever been treated or diagnosed as having any of the following conditions? Please circle if *yes*

Diabetes	Anemia	Glaucoma
Heart Disease	Prolonged Bleeding	Venereal Disease
High Blood Pressure	Low Blood Pressure	Sickle Cell
Hepatitis	Liver Disease	Phlebitis
Stroke	Rheumatic Fever	Tuberculosis
Kidney Disease	Scarlet Fever	Seizures
Ulcer	Stomach Problems	Cancer
Arthritis	Gout	

Other____

Medications____

Are you *ALLERGIC* or *SENSITIVE* to any of the following? Please circle if *yes*

Aspirin	Penicillin	Antibiotics	Novocain
Motrin	Cortisone	Adhesive Tape	Iodine

Other______________________________

What foot problem brings you to our office?______________________________

Cherryvale Plaza
11710 Reisterstown Rd. #208
Reisterstown, MD 21136
(410) 833-0040
Fax: (410) 833-0574

Columbia
10796 Hickory Ridge Rd.
Columbia, MD 21044
(410) 977-1133
Fax: (410) 833-0574

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Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, and "Doctor" refers to entity listed above

I consent to the use or disclosure of my protected health information by Doctor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Doctor. I understand that analysis, diagnosis or treatment of me by Doctor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Doctor is not required to agree to the restrictions that I may request. However, if Doctor agrees to a restriction that I request, the restriction is binding on Doctor. I have the right to revoke this consent, in writing, at any time, except to the extent that Doctor has taken action in reliance to this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Doctor and understand that I have the right to review this Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation of Doctor. The Notice of Privacy Practices for Doctor is posted in the waiting room at ***11710 Reisterstown Rd; Suite 208 Reisterstown, MD 21136***. This notice of Privacy Practices also describes my rights and duties of the Doctor with respect to my protected health information.

Doctor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office of Doctor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative | Printed Name of Patient

Date of signing | Description of Personal Representative's Authority

CherryVale Plaza
11710 Reisterstown Rd, #208
Reisterstown, MD 21136
410-833-0040* Fax 410-833-0574

Columbia
10796 Hickory Ridge Rd
Columbia, MD 21044
410-997-1133* Fax 410-997-2441

MARK E. SPIER, DPM
COLUMBIA FOOT HEALTH CENTER
ROTUNDA FOOT AND ANKLE CENTER

FINANCIAL POLICY

FULL PAYMENT OF HMO/PPO COPAYS IS DUE PRIOR TO SERVICE. FULL PAYMENT IS DUE AT THE TIME OF SERVICE FOR ALL SERVICES NOT COVERED BY YOUR INSURANCE, OR WHEN YOUR DEDUCTIBLE HAS NOT BEEN MET.

WE ACCEPT CASH, CHECKS, MC AND VISA

REGARDING INSURANCE

Your insurance is a contract between you and your insurance company. Please be aware that some and perhaps all of the services provided might not be covered services (or not considered "medically necessary" under the Medicare program) and are therefore your responsibility. If your insurance company has not paid your bill within 45 days, the balance will be billed to you. IF YOU BELONG TO AN HMO OR PPO, FULL PAYMENT IS YOUR RESPONSIBILITY IF YOUR INSURANCE COMPANY DOES NOT PAY OUR BILL FOR ANY REASON, INCLUDING LACK OF PROPER REFERRAL OR INADVERTENT RENDERING OF AN IN OFFICE DIAGNOSTIC TEST THAT IS LATER DENIED AS NOT PAYABLE. **THIS IS TO ADVISE YOU THAT WE DO *NOT* BELONG TO ALL HMO NETWORKS.**

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best care for our patients and we charge what is usual and customary for our area. You are responsible for ***ALL*** deductibles, co pays and coinsurance amounts. We cannot ***write off*** any amount that is your responsibility.

MISSED APPOINTMENTS

We reserve the right to charge for appointments not cancelled at least 24 hours in advance. Please help us serve you better by keeping scheduled appointments.

PAST DUE ACCOUNTS

Accounts are considered past due after 30 days. An account that needs to be re-billed will be charged a re-billing finance charge of 1 ½% or $8.00 per month, whichever is greater. A service charge plus the re-billing fee will be added to your account if your check is returned from your bank for any reason. Bills turned over to our collection agency will be subject to a **collection surcharge of 40% of the account balance.** Additional fees will apply if the account is forwarded to an attorney for a collection lawsuit.

OVERPAYMENTS

All overpayments are credited to your account. Overpayments over $20.00 will be refunded to you. Overpayments under $20.00 will remain credited to your account for future use unless your request a reimbursement.

I have read, understand and agree to this financial policy

X____**Date**_______________________________
Patient and/or Guarantor (SEAL)

X____**Date**_______________________________
Parent or Guardian if patient is a minor

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To Our Patients,

Unfortunately, our operating expenses, including rent, malpractice insurance premiums, governmental surcharges and other office expenditures continue to rise every year. During this same time period, insurance reimbursement has continued to decrease for many of our services.

Therefore, it has become necessary to impose an administrative fee of $5.00 per visit, effective October 1, 2004. This will be separate from any copay and/or coinsurance due, and is not covered by your health insurance. This fee will cover HIPPA and OSHA compliance expenses as well as additional ancillary services such as completion of extraneous paperwork and after hours consultation as required.

We regret that we have been forced to add this fee, but we can no longer provide the caring, personal service to our patient's in todays environment of decreasing insurance payments and escalating overhead expenses.

Please acknowledge your acceptance of the voluntary fee by signing on the line below.

Thank you for understanding

I agree to pay an administrative fee of $5.00 each visit_______________________________________

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Dear Patient,

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

Payment arrangements are required at the time of your visit

We now offer the following payment options,

__ Cash

__Check

__MC or Visa

__Automatic monthly billing to your MC or Visa

Please make your choice, sign below and return to the office manager before treatment.

Our office is a fully approved and accredited user of MC and Visa Health Care Program which will enable you to use your MC or Visa card to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your MC or Visa on a monthly basis.

____

Print Name

____

Sign name Date

Pre-Authorized Healthcare Form

I authorize ______________________________
(name of healthcare provider)
to keep my signature on file *and* to charge my MasterCard® or Visa account as indicated below:

Check One: ☐ MasterCard ☐ Visa

☐ Balance of charges not paid by insurance within 90 days and not to exceed $ ________ for (indicate one):

☐ this visit only.

☐ all visits this year.

☐ Recurring charges (on-going treatments) of $ ____________________ .
every ________ (frequency) from ________ (date) to ________ (date) .

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider.

____
Patient Name

____
Cardholder Name

____
Cardholder Billing Address

____
City State Zip

______________________________ Mo.______ Yr.______
Account Number Expiration Date

X ______________________________
Cardholder Signature Date

Provider Copy - White **Patient Copy - Yellow**