Cory Brown, DPM

1630 23rd Ave., Suite 1001 Lewiston, ID 83501

First name *Middle Initial* *Last name*

Email

Mailing Address

City **State** **Zip**

Phone **Date of Birth**

Marital Status **Gender**

Height **Weight** **Shoe size**

*** Race**

**This information is requested due to Healthcare Reform laws dictated by Congress.*

Are you pregnant **Are you nursing**

Primary Care Physician

Pharmacy

Who referred you to our office?

Primary Reason for Visit

Duration of Condition

What helps?

What makes it worse?

Is it limiting your desire activity level?

Please list any drug allergies

List Medications You Take

Medical History

- □ **Diabetes**
- □ **Heart disease**
- □ **Kidney failure**
- □ **On blood thinners**
- □ **Neuropathy**
- □ **Hypertension**

What surgeries have you had?

Is your problem related to a Workman's Comp injury or an auto/other accident _____

Social History

Do you drink alcohol _____ **How often** _____

Do you smoke, vape or use chewing tobacco _____

Specify _____ **How many per day** _____

Do you have/have had a substance abuse problem _____ **Specify** _____

Family History

Diabetes _____ **Stroke** _____

Cancer _____ **Arthritis** _____

Heart Attack _____ **HTN** _____

Emergency Contact

First Name _____ **Last Name** _____

Relationship to Patient _____ **Phone** _____

Responsible Party (if minor patient)

First Name _____ **Last Name** _____

Relationship to Patient _____ **Date of Birth** _____

Insurance Information

Subscribers name _____ **Subscribers D.O.B.** _____

Patient's Relation to the Subscriber _____ **HMO** _____

Primary Insurance _____

Policy Number _____ **/ Group#** _____ **Policy Holder Date of Birth** _____

Policy Holder Name _____

Secondary Insurance _____

Secondary Policy Number _____ **/ Group#** _____

Occupation _____

Employer _____

For any insurance plan that requires authorization from a primary care physician (e.g. HMO, PPO, etc.) it is your responsibility (as patient or guardian) to be sure that this office receives all necessary referrals or authorizations PRIOR to treatment. Professional services are rendered and billed directly to your insurance carrier; however you, the patient/guardian, are directly responsible for services rendered by the doctor. A health insurance policy is a contract between you (the patient or subscriber) and your insurance carrier. You MUST notify this Office of any changes to your insurance policy including policy termination, changes in co-payments or a new insurance policy. If for any reason the insurance carrier denies charges, payments for any services rendered will become the responsibility of the patient/guardian.

I Agree ( )

All office visit charges and co-pays are due at the time services are rendered. It is the patient themselves whom are responsible for their financial aspects of services rendered. There will be a charge for returned checks, missed appointments without 24 hours notice and completion of any forms. I agree to pay for all deductibles, co-pays, non-covered services and any portion of covered services not paid in full by my insurance plan and understand that such payments are due at the time of service or immediately upon presentation of the bill. I hereby name Cory Brown, DPM (CBDPM) as my assignee. I Instruct my health care benefits plan administrator, i.e. PLAN to pay CBDPM directly for all professional and medical services provided by CBDPM. through the means of electronic funds transfer(s} (EFT} or by check(s) made payable to and mailed to CBDPM. I AUTHORIZE THE RELEASE IF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS.

I Agree ( )

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. • I also give permission for photographs of my feet to be taken that are to be kept as part of my medical record only. They will not be published as part of medical research or disbursed in any way without my permission.

I Agree ( )

I acknowledge that I was provided a copy of the **Notice of Privacy Practices for Cory Brown, DPM.** and I have read (or had the opportunity to read if I so choose) and understood the Notice. There is a copy of our privacy policy at our front desk and on our website.

I Agree ( )

PAYMENT RESPONSIBILITIES

We are pleased to welcome you to our office. New Patients are always appreciated. Our practice has grown as a result of its excellent relationship with our referring doctors and patients. As our patient, please feel free, at any time, to express any concerns or to ask any questions that you may have for the doctor or our staff. In order to assist you in making payment(s) for your podiatric treatment, the following options are listed. Please read them carefully and feel free to discuss them with us.

If you DO NOT have insurance: Payment is due, in full, at the time treatment is provided.

*For your convenience, we accept all major credit/debit cards and cash. We accept personal checks for payments under $50.00.

If you have Insurance: The percentage of coverage by your insurance company may be based on your insurance company's own reduced fee schedule for medical services and may be less than actual charges resulting in lower coverage for you. Cory Brown, DPM has no control over this situation. *Lower payment is a direct result of the plan selected by you or your employer.* **Please be advised that we cannot waive co-payment. We are required by law to collect co-payment.**

Commercial Insurance: We will submit your claim to your insurance carrier for you. You are responsible for any deductible or co-payment not covered by your insurance. Once our office has received payment from the insurance company, you will be billed, with 30 day terms, for any amount still owed. You may choose to keep a credit card on file for those balances left to you by your insurance company.

Medicare: This office accepts Medicare assignment. Medicare patients are fully responsible, however, for the initial yearly deductible and the 20% co-insurance. Federal law requires that physicians collect this amount. If you have a secondary insurance to cover the 20%, we will submit the balance to that insurance for payment and you will only be responsible for the yearly deductible.

Signature *Date*

Cory Brown, DPM

1630 23rd Ave., Suite 1001 Lewiston, ID 83501

HIPAA Privacy Authorization
Authorization for Use or Disclosure of protected health information required by the Health Insurance Portability and Accountability Act.

- I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information described below.
- This medical authorization may be used by the person(s) I authorize to receive this information for medical treatment, billing, claims, payment, or other purposes noted unless otherwise stated.
- I understand that I have the right to revoke or change this authorization at any time.
- I understand that information used or disclosed to listed person(s) may no longer be protected byfederal law.

1. _____

Name of Authorized *Relationship*

2. _____

Name of Authorized *Relationship*

3. _____

Name of Authorized *Relationship*

***** _____ _____

Patient Signature *Date*

******Authorization is active for 1 year of date of signature*