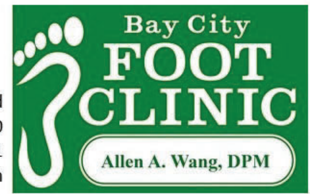
From the office at Bay City Foot Clinic

Dr. Allen A. Wang, DPM

Essexville and Linwood
Phone: (989) 671-9930
Fax: (989) 671-9901
baycityfootclinic@gmail.com



New Patient Form (please print)

Today's Date ____/____/____ Facility ____________________ Doctor ____________________

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Mrs. ☐ Dr. ☐ Miss	☐ Sr. ☐ Jr.

Street Address	City	State	Zip Code

Home Phone #	Work Phone #	E-mail Address
( ) -	( ) -	

Birth Date	Age	Social Security Number	Marital Status	Sex
/ /			☐Single ☐Mar ☐Widow ☐Div	☐ M ☐ F

INSURANCE INFORMATION

Occupation	Insured Employer

Insured Employer Address

Please indicate primary insurance	Address of primary insurance carrier	Phone number ( ) -

Insured Name	Insured S. S. #	Insured ID	Policy Group #	Eff. Date	Co-Payment

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other **Insured Birth Date** /   /

Insurance Type ☐ PPO ☐ EPO ☐ HMO ☐ POS ☐ Self Pay ☐ Medicare ☐ Public Aid ☐ WC ☐ OTHER ____________.

Please indicate secondary insurance	Address of secondary insurance carrier	Phone number ( ) -

Insured Name	Insured S. S. #	Insured ID	Policy Group #	Eff. Date	Co-Payment

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other **Insured Birth Date** /   /

Insurance Type ☐ PPO ☐ EPO ☐ HMO ☐ POS ☐ Self Pay ☐ Medicare ☐ Public Aid ☐ WC ☐ OTHER ____________.

Referred to Institute by (Please use one) **Address**

☐ Doctor ____________________ ____________________

☐ Hospital ____________________ ____________________

☐ Insurance Plan ____________________ ____________________

☐ Family ____________________ ____________________

☐ Friend ____________________ ____________________

☐ Tribune ☐ Herald ☐ Sun Times ☐ T.V ☐ Radio ☐ Other ____________________

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
To Bay City Foot Clinic

X ____________________ /   /
Signature Date

HIPAA AUTHORIZATION
Necessary to process claims

X ____________________ /   /
Signature Date

COMMUNICATION AUTHORIZATION
I authorize Bay City Foot Clinic to contact me via phone, text, fax, mail and email

X ____________________ /   /
Signature Date

MEDICAL HISTORY

PATIENT NAME	BIRTH DATE	/ /

ALLERGIES (LIST KNOWN ALLERGIES OR REACTIONS TO DRUGS/MEDICATIONS)

☐ Penicillin	☐ Sulfa	☐ Local Anesthetic	☐ Anti-inflammatory Medication
☐ Codeine	☐ Tape	☐ Nausea From Anesthetic	☐ Iodine on Skin

MEDICATIONS *(PLEASE LIST CURRENT MEDICATIONS THAT YOU ARE TAKING: PRESCRIPTION AND OVER THE COUNTER)*

MEDICATION	DOSE	MEDICATION	DOSE

FOOT/ANKLE PAIN WHERE?	HOW LONG?	MONTHS	YEARS

WHAT PREVIOUS TREATMENT HAVE YOU HAD ON YOUR FOOT/ANKLE?

☐ Surgery	☐ Orthotics	☐ Oral Medications	☐ Cortisone Shots

FAMILY PHYSICIAN INFORMATION

Medical Doctors Name	Phone Number ( ) -		
Street Address	City	State	Zip Code

Have you ever been put to sleep for surgery? ☐ Yes ☐ No

SHOE SIZE		HEIGHT	WEIGHT
DO YOU DRINK?	☐ NO	☐ YES	DRINKS PER WEEK
DO YOU SMOKE?	☐ NO	☐ YES	PACK(S)/DAY

Indicate which of the following you have had or have at present. Check Yes or No to each item

Arthritis/Rheumatism	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Artificial Joints (hip, knee, etc.)	☐ Yes	☐ No	H.I.V. Positive	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	Motion Sickness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Neurological Disorder	☐ Yes	☐ No
Heart (Surgery, Disease, Attack)	☐ Yes	☐ No	Psychiatric/Psychological Care	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Stomach Problems / Reflux / Heartburn	☐ Yes	☐ No
Hepatitis A (Infectious) B (serum)	☐ Yes	☐ No	Ulcers (Diabetic)	☐ Yes	☐ No

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

X	/ /
Patient/Guardian Signature	Date

HISTORY REVIEWED BY: DR. SIGNATURE DATE

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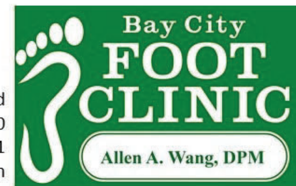

Today's Date _____/_____/_____ Facility ___________________________ Doctor ____________________

PATIENT INFORMATION

Patient's Last Name	First	Middle	Birth Date
			/ /

DEMOGRAPHICS (FOR GOVERNMENTAL STATISTICAL ANALYSIS)

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Black or African American ☐ White ☐ Hispanic ☐ Other Pacific Islander ☐ Other Race ☐ I Decline to Report

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ I Decline to Report

Preferred Language ☐ English ☐ Spanish ☐ Other ____________________________

PHARMACY / PRESCRIPTION INFORMATION

Preferred Pharmacy:

☐ Costco ☐ CVS ☐ Osco ☐ Target ☐ Wal-Mart ☐ Walgreens ☐ Other ____________________________

Address or Cross-Streets: ____________________________

City: ____________________________

State: __

Zip Code: ____________________________

Phone Number: ____________________________

Fax Number: ____________________________

☐ This is a mailorder pharmacy

☐ I do not have a preferred pharmacy

I authorize Bay City Foot Clinic and its affiliated providers to view my external prescription history via the Surescripts service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

To Bay City Foot Clinic

X ____ / /

Signature Date

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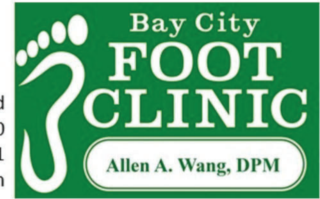

Bay City Foot Clinic Financial Policy

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibilty on your part.

Insurance: We participate in most insurance plans. If you are not insured by a plan we participate with payment in full is expected at time of visit. Knowing your insurance plan and benefits is your responsibilty. Please contact your insurance provider with anny questions you may have regarding your coverage, copays and deductables. If you are need of a referral to the doctor that is your responsibility to make sure you have the referral on your appointment and have it renewed if expired.

If you do not have an appropriate referral or if seen without a referral when a referral is required, it will be your responsibilty to pay the charges that incur on your visit.

Medicare: We are participating Medicare Provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered byb Medicare. Patients are responsible for paying their annual deductibles if not met already. You are responsible for any copayments which usually (not always) are 20% of the allowed amount for a unit of service provided.

Secondary Insurance: your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance coverage.

Co-payments and Deductibles: All co-payments and Deductibles must be paid at the time you receive service.

Self-Pay : Payment in full is due at the time of service.

Non-Covered Services: Please be aware that some of the services you may receive, may not be covered or not considered to be reasonable or necessary by Medicare or other insurance proividers.

You are responsible for payment of these services.

Claim Submission: We will submit your claims and assist you in any way we reasonably can, to help get your services paid. Your insurance provider may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance provider.

Patient Billing: You will be mailed up to three notices for your financial responsablity (copayments/Deductable) after payment and/or explanation of benefits (EOB) is received from your insurance provider (s).

After the third and last notice, your account may be forwarded to small claims court. Please let the billing office know if you are having difficulties with resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check, Credit Card, and Money orders.

An additional $30.00 fee will be added to your statement if the check is returned as Non suffient funds.

In the event that your insurance company should happen to send payments to you, the patient, we expect that you would forward to our office to be applied to your account balance.

FAILURE to come for your scheduled appointment without providing 12 hours notice will result in you being charged $50.00 for office appointment and $100.00 for surgical appointments. Another appointment will not be scheduled, until this fee is paid.

I have read the above policies regarding my financial responsibilities to Bay City Foot Clinic (Dr. Allen Wang DPM and Allen A. Wang DPM PC) for medical services provided. I agree to pay Bay City Foot Clinic (Allen A. Wang DPM PC) any balance unpaid by my insurance provider(s), for myself or name listed below. I understand that it is my responsibility to inform the doctor office if there are any changes to my health information.

Patient Signature/Responsible party: ______________________ **Date:** ______________

Printed name: ____

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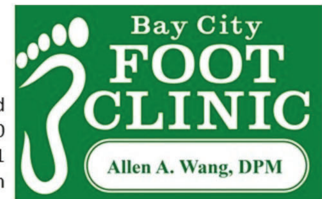

INSURANCE:

ASSIGNMENT AND RELEASE:

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDANT) HAVE INSURANCE COVERAGE WITH ________________________ AND ASSIGN DIRECTLY TO ALLEN A. WANG DPM PC, ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICE RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHEATHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

________________________________ ________________________________
PATIENT OR REPRESENTATIVE DATE

MEDICARE AUTHORIZATION:

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO DR. ALLEN A. WANG D.P.M, FOR ANY SERVICE FURNISHED ME BY THAT PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICE. I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO APPLY THE CLAIM. IF "OTHER HEALTH INSURANCE" IS INDICATED IN ITEM 9 OF THE HCFA-1500 FORM, OR ELSEWHERE ON OTHER APPROVED CLAIM FORMS OR ELECTRONICALLY SUBMITTED CLAIMS, MY SIGNATURE AUTHORIZES RELEASING OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. IN MEDICARE ASSIGNED CASE, THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE FOR THE DEBUCTIBLE, COINSURANCE, AND NONCOVERED SERVICES. COINSURANCE AND THE DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER.

________________________________ ________________________________
PATIENT OR REPRESENTATIVE DATE

NON-COVERED SERVICES BY PROVIDER INSURANCE COVERAGE:

Please note the following non-covered services by various insurance providers.
Some carriers will only pay for certain procedures of medical care provided. Other companies require a pre-set deductible amount to be met as a requirement of coverage for balances thereof. Other companies may or may not cover office calls and initial consultations. We believe that, in your case, payment may be denied for reasons deemed by insurance guidelines of the following services:

______Orthotics	______Orthopedic Padding	______Ankle Braces
______Arch Supports	______Routine Foot Care	______DTM Culture
______Surgical Shoes	______Corn/Callous Treatment	______Misc. Treatment

________________________________ ________________________________
SIGNATURE DATE

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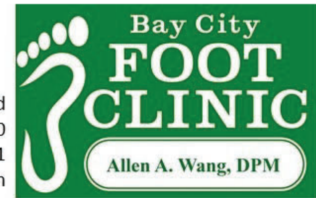

Patient Privacy and Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for use and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print name: ______________________ Signature:____________________________ Date: ______________________

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.