Dr. David F. Corcoran - Doctor of Podiatric Medicine

Insurance: Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Corcoran all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether 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.

_____ _____

Print Name Patient / Responsible Party Signature

_____ _____

Relationship Date

Medicare Authorization:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Corcoran for any services furnished me by Dr. Corcoran. 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 services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay 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 cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

Patient Financial Policy Notice:

Responsible Party Name:_____DOB_____SS#_____Relationship to Patient_____

Our office is currently utilizing an outside billing service. As a courtesy to you, we will bill your insurance carrier(s) for any services rendered.

Be it understood that insurance does not pay for all services rendered or medical equipment dispensed, I understand that I am ultimately responsible for the balance on my account for any professional services rendered. I further agree to give notice of any changes in insurance coverage and health status in a timely manner to avoid any delay in billing. I agree that after insurance determination on any claim has been made and upon receipt of a statement of patient balance due responsibility, I will make prompt payment to the office – within 10 days. Any balance which is not paid will be considered past due. In the event I make it necessary for Acclaim Foot and Ankle Center, P.C. to turn my account over for collections, I understand that I will be responsible for any and all collections fees as well. I sign below to acknowledge my understanding and willingness to comply with this Patient Financial Policy Notice.

_____ _____

Patient / Responsible Party Signature Date

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Authorization for Release of Medical Records and/or Information

I authorize the release of photocopies of the following medical records and/or Xray films in the possession of Acclaim Foot and Ankle Center, P.C., it's employees and/or agents. For the purpose hereof, "Medical Records and X-Ray Films" shall include all confidential HIV related information (as defined in A.R.S. Section 36-661) Confidential Communicable Disease related information as defined in (R.R.S. Section 36-3661), Confidential alcohol or drug abuse related information as defined in 42 (FR Section 2.1 ET SEQ), and confidential mental health diagnosis/treatment information.

I authorize Acclaim Foot and Ankle Center, P.C., to release medical information and/or discuss all matters related to my treatment and/or care to the entities indicated below. I understand that confidentiality cannot be guaranteed.

Primary Care Physician: _____

_____

Other Physicians: _____

_____

Family and/or Other persons: (please list names and relationship)

Name:_____ Relationship:_____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I Authorize Acclaim Foot and Ankle Center, P.C., to leave results or detailed messages on the below number.

Phone Number: _____ Hours: _____

Patient Signature: _____ Date: _____

Acclaim Foot & Ankle Center

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**Reason for Visit:_____

Date Symptoms Began:_____Were you seen elsewhere? (circle) yes no
Facility:_____

Is complaint due to: Auto Injury? (circle) yes no Personal Injury? yes no Work Injury? yes no

Worker Comp Claim #_____Insurance Co_____Phone_____

Do you have Pain? (circle) Yes No Left Right Foot Ankle Leg When did pain start?_____

Pain Scale (1=minimal to 10= severe) Rate your pain _____. Describe your Pain_____

Diabetic? (circle) yes no If yes, date last seen by primary care physician_____Last A1c_____
Date of last Podiatry Visit:_____

Primary Care Physician:_____Phone:_____Fax:_____

Preferred Pharmacy:_____Phone:_____Fax:_____
Address:_____

Do you have a durable power of attorney for healthcare?(circle) yes no Current copy provided? yes no

Medical History

Please circle "c" for current and "p" for past issues

AIDS/HIV	c / p	Diabetes	c / p	Psychiatric Care	c / p
Allergy to Anesthetic	c / p	Hearing Loss	c / p	Radiation Therapy	c / p
Anemia	c / p	Eye Issues	c / p	Rash	c / p
Angina	c / p	Fainting	c / p	Respiratory Disease	c /p
Arthritis	c / p	Foot/Leg Cramps	c / p	Rheumatic Fever	c /p
Artificial Valves/Joints	c / p	Gout	c / p	Shortness of Breath	c /p
Asthma	c / p	Headaches	c / p	Sinus Problems	c / p
Back Issues	c / p	Heart Disease	c / p	Stroke	
Bleeding Disorder	c / p	Hemophilia	c / p	Swelling Ankles/Feet	c/ p
Cancer	c / p	Hepatitis	c / p	Swollen Glands	c / p
Chemical Abuse	c / p	High Blood Pres.	c / p	Tuberculosis	c / p
Chest Pain	c / p	Kidney Problems	c / p	Ulcers	c / p
Circulatory Issues	c / p	Lupus	c / p	Varicose Veins	c / p
COPD	c / p	Nervous Issues	c / p	Venereal Disease	c / p
Seizures	c / p	Phlebitis	c / p	Sleep Apnea	c / p
Valley Fever	c / p	Thyroid Disease	c / p	Weight Loss	
		Valley Fever	c / p	unexplained	c / p

Patient/Guardian Signature: _____ Date: _____

Acclaim Foot & Ankle Center

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List name and dosage _____

_____

_____

If you do not take any medications – write "no medications" _____
If you have provided a list of your medications – write " medication list provided" _____

Do you take herbs or supplements? Please list _____

_____

Do you take oral contraceptives Yes ___ No ___ Current Height: _____ Current Weight: _____

Allergies: Please indicate if you have allergies to the following by marking "X" to any that apply.

Adhesive / Tape ___ Anticoagulant Therapy ___ Aspirin ___ Codeine ___

Iodine ___ Local Anesthetics ___ Novocaine ___ Penicillin ___

Seafoods ___ Sulfa ___ Other _____

Surgeries you have had: _____

_____

Hospitalizations: (other than for surgeries) _____

_____

Family Medical History: Please indicate in space provided if any parent, grandparent, or sibling has history of any of the following
conditions. Diabetes, Heart Disease, Hypertension, Cancer (list type), Other.

_____

Social History: (Circle all that apply)
Alcohol Use: Frequent Social Never Alcohol / Drug abuse history requiring treatment? Yes __ No ___
Tobacco Use: Smoking Current _____packs/week Former Smoker – Past _____packs/week
Tobacco Type: (Circle one) Cigarettes Cigars Other _____ Never Smoked

Patient / Guardian Signature:_____ Date:_____

Acclaim Foot & Ankle Center

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Patient Information

Last Name:_____ First Name:_____ Initial:___ DOB_____ SS#_____

Address:_____

Marital Status:_____ Gender:_____ Race:_____ Ethnicity:_____

Your Approved Methods For Communication:

( ) Cell Phone ( ) Home ( ) Work

EMAIL:_____ *Best method to reach you?* _____

Occupation:_____ Employer:_____

Employer Address:_____ Phone:_____

Emergency Contact:_____

Name Cell Phone Home Phone Work Phone

Relationship to Patient:_____

Insurance Information

Primary Insurance:_____ Policy#:_____ Group/Network:_____

Policy Holder:_____ DOB:_____ Relationship to Patient:_____

Claims-Billing Address:_____ Phone:_____

Secondary Insurance:_____ Policy#:_____ Group/Network:_____

Policy Holder:_____ DOB:_____ Relationship to Patient:_____

Claims-Billing Address:_____ Phone:_____

Guarantor Information: (person financially responsible for patient's account)

Last Name, First DOB Relationship

Street Address City State Zip

How were you referred? Physician:_____ Family / Friend / Internet_____

Patient/Guardian Signature: _____ Date: _____