REGISTRATION

WELCOME TO THE OFFICE

Last Name [ ] First Name [ ]

Address [ ]

Contact information for results of tests and appointment changes due to problems:

Home Phone [ ] Cell Phone [ ]

E- Mail [ ]

Employer & Phone [ ]

Social Security Number [ ] Date of Birth [ ]

Driver's License Number [ ]

Acknowledgement of Receipt of Notice of Privacy Practices, Consent, and Acceptance of Office Payment Policies

I hearby acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read if I so chose and understood the notice.
By signing below I consent to general treatment and examination by Dr. John A. Brandeisky. This includes minor procedures with local anesthetic. In case I am uncomfortable with this situation, I will ask for a specific consent form for the treatment proposed for this or future visits. By signing below I also consent to the filing of my insurance claim on my behalf by the office of Dr. John A. Brandeisky, DPM, FACFAS Surgeon * Podiatrist. By signing below it means you request that payment of authorized benefits be made on your behalf to Dr. John A. Brandeisky, DPM, FACFAS Surgeon * Podiatrist for any services furnished to me by that provider or service. I authorize any holder of medical information about me to release to the Heath Care Financing Administration (or other insurance company) and its agents any information needed to determine these beneifts or the benefits payable for related service. The same applies to my medigap insurance if any which is noted in the chart and computer records. I will also accept responsibility for non covered services.
I understand this also applies to a minor (under 18) under my care as a parent or guardian.
Any part of this Acknowledgement or Consent I don not agree with has been stricken by me prior to signing.
Finally *I am aware that I am responsible for all referrals to secure payment as well as accuracy of who my insurance carrier(s) is / are and that ultimately I am responsible for all charges incurred during my visits. I realize bounced checks represent fraud / theft and incur a fee of $50.00 in addition to funds owed and liens on property incur a $100.00 fee.*

Please be sure to show us ALL INSURANCE THAT COVERS YOU TO BEST SERVE <u>YOU !</u> Also, any time your insurance changes you must tell us so we do not bill you erroneously.

____Today's Date is: _______________

Your Signature for Above