St. Augustine
Foot, Ankle & Vein
Conservative care you can count on

PATIENT REGISTRATION PACKET

This packet must be filled **completely** before your appointment

1. PATIENT INFORMATION

Full Name: _____ Date of Birth:_____

Preferred Name: _____ Social Security Number: _____

Legal Sex Assigned At Birth: Male Female
Current Gender Identity: Male Female Non-Binary Prefer Not To Disclose

Primary Language: English Spanish Other _____

Address: _____

City:_____ State: _____ ZIP: _____

Cell Phone: _____Home Phone: _____

Email: _____

Preferred Appointment Reminder: Text Voice Email
Patient Portal: Yes No

2. EMERGENCY CONTACT

Emergency Contact Full Name: _____

Relationship: _____Phone #: _____

3. REFERRAL SOURCE

How did you hear about us?

Physician Friend/Family Existing Patient Google Search Google Ad

Facebook Page Facebook Ad Insurance Directory Walk-in Yard Sign

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INSURANCE INFORMATION

4. INSURANCE

Primary Insurance Company: _____

Member ID: _____ Group #: _____

Complete the following if you are NOT the policy holder

Policy Holder: _____ Date of Birth: _____

Relationship: Spouse Parent Child Other _____

Secondary Insurance Company: _____

Member ID: _____ Group #: _____

Complete the following if you are NOT the policy holder

Policy Holder: _____ Date of Birth: _____

Relationship: Spouse Parent Child Other _____

5. RELEASE OF MEDICAL INFORMATION TO FAMILY/FRIENDS

I authorize St. Augustine Foot, Ankle & Vein to discuss my protected health information with:

Full Name _____ Relationship _____ Phone: _____

Full Name _____ Relationship _____ Phone: _____

6. PRIVACY NOTICE

I have received a copy of the practice's current HIPAA Notice of Privacy Practices as a separate document.

Patient Initials: _____

7. FINANCIAL POLICY ACKNOWLEDGEMENT

I have received a copy of the practice's current Financial Policy Acknowledgement as a separate document.

Patient Initials: _____

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MEDICAL INFORMATION

Patient Name: _____ DOB: _____

8. PRIMARY CARE PHYSICIAN

Primary Care Provider: _____ Last Visit: _____

Facility Name & Address: _____ Phone: _____

9. REASON FOR TODAY'S VISIT

Referring Physician: _____

Description of Problem: _____

Date Symptoms Began/Date of Injury: _____

Are You **Diabetic**? Yes No Not Sure

10. MEDICATIONS & ALLERGIES

Current Medical Conditions (attach list if needed):

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

Preferred Pharmacy: _____ Phone: _____

Allergies: _____

I certify that the information I have provided is true and accurate to the best of my knowledge.

Patient Signature: _____ **Date**: _____

1 Saint Johns Medical Park Drive, St. Augustine, FL 32086 | Phone: (904) 824-0869 | Fax: (904) 826-0966

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NOTICE OF PRIVACY PRACTICES

- We maintain safeguards to ensure the security and confidentiality of your personal information. These safeguards include physical security within our facility, password-protected databases, compliance audits, and virus/intrusion detection software. Access to your information is limited to staff members who require it to perform their job duties. We are committed to protecting and responsibly using your protected health information. This Notice of Privacy Practices describes the information we collect and how it may be used or disclosed. This notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.
- Each time you visit our office, a record of your visit is created. This record typically includes your symptoms, examination and test results, diagnoses, treatment, and plans for future care or treatment. This information, often referred to as your health or medical record, serves as the basis for planning your care and treatment; a means of communication among the healthcare professionals involved in your care; legal documentation of the care you received; a means by which you or a third-party payer can verify that services billed were provided; a tool for educating healthcare professionals; a source of data for medical research; a source of information for public health officials responsible for improving the health of the community and nation; a source of data for planning and marketing; and a tool for continually assessing and improving the quality of care we provide. Although your medical record is the physical property of this practice, the information it contains belongs to you.
- You have the right to obtain a paper copy of this Notice of Privacy Practices upon request; inspect and obtain a copy of your health record as provided by 45 CFR 164.524 (reasonable copy fees may apply in accordance with state law); request an amendment to your health record as provided by 45 CFR 164.526; obtain an accounting of disclosures of your protected health information as provided by 45 CFR 164.528; request confidential communications of your protected health information as provided by 45 CFR 164.522(b); and request restrictions on certain uses and disclosures of your information as provided by 45 CFR 164.522(a), although we are not required by law to agree to every requested restriction.
- Our practice is required to maintain the privacy of your protected health information; provide you with this notice describing our legal duties and privacy practices regarding the information we collect and maintain; abide by the terms of this notice; notify you if we are unable to agree to a requested restriction; and accommodate reasonable requests regarding confidential communications of your protected health information.
- We reserve the right to change our privacy practices and make the new provisions effective for all protected health information we maintain. A current copy of this notice, including its effective date, will be posted in our office. You may also request a copy of the current notice at any time.
- We will not disclose your protected health information in any manner other than as described under **Examples of Disclosure for Treatment, Payment, and Health Care Operations** without your written authorization, which you may revoke as provided by 45 CFR 164.508(b)(5), except to the extent that action has already been taken in reliance upon your authorization.
- Examples of Disclosure for Treatment, Payment, and Health Care Operations: We may use your health information for treatment by providing medical information to healthcare providers, practice personnel, or others involved in your care. We may use and disclose your health information for payment so we can bill and collect payment for the healthcare services you receive. We may also use your health information for routine healthcare operations, including administrative, financial, legal, and quality improvement activities necessary to operate our practice.
- Consistent with applicable law, we may disclose your health information to provide appointment reminders; to coroners, medical examiners, or funeral directors; for workers' compensation or similar programs established by law; to public health or legal authorities responsible for preventing or controlling disease, injury, or disability; to researchers whose studies have received appropriate Institutional Review Board or Privacy Board approval; to organ procurement organizations or other entities involved in organ, eye, or tissue donation and transplantation; as required by law, including reporting crimes or responding to court orders, subpoenas, warrants, discovery requests, or other legal processes; for health oversight activities such as audits, investigations, and inspections; for military, veterans', national security, or intelligence activities; to business associates who perform services on our behalf and are required to safeguard your protected health information; to the U.S. Food and Drug Administration (FDA) for reporting adverse events, product defects, recalls, post-marketing surveillance, or other FDA-related activities; to your personal representative or another individual legally authorized to act on your behalf; when we believe in good faith that disclosure is necessary to prevent or lessen a serious threat to your health or safety or that of another person, including situations involving abuse, neglect, or domestic violence as permitted by law; to family members or close personal friends involved in your care or payment for your care; and to organizations assisting in disaster relief efforts.
- For all non-routine disclosures, we will obtain your written authorization before releasing your protected health information. We take great care to safeguard your information and make every reasonable effort to minimize incidental disclosures while providing you with quality healthcare.

Patient Signature: _____ **Date:** _____

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FINANCIAL POLICY ACKNOWLEDGEMENT

Financial Policy – Welcome to our office. We are committed to providing you with the highest quality care. We accept cash, checks, and all major credit cards. To help us better serve you, please take a few moments to read the following policies regarding our practice and your insurance coverage.

Insurance – If you have insurance, we will make every effort to help you receive the maximum benefits available under your plan. Please understand that your insurance company's payment may be based on its own fee schedule and may be less than our actual charges, resulting in a remaining balance for which you are responsible. We have no control over your insurance company's payment policies. The amount paid is determined by the plan selected by you or your employer. Please note that we are required by law to collect all applicable co-payments and cannot waive them.

Medicare Patients – We accept Medicare. Medicare patients are responsible for their annual deductible and the 20% co-insurance. Payment is due at the time services are rendered.

Medical Records, Releases, and Insurance Assignments – I authorize Dr. LeBeau, the Physical Therapist, or their designated assistant to provide podiatric and/or physical therapy treatment. I also authorize this office to obtain photographs for medical purposes when necessary. I authorize a copy of these authorizations and assignments to be used in place of the original, which will remain on file at this office.

Physician Insurance Assignment – I authorize payment of surgical and/or medical benefits directly to Thomas LeBeau, DPM. Any services for which insurance benefits are not assigned or not covered are my sole financial responsibility.

Medicare/Medicaid – I certify that the information I have provided in applying for benefits under Title XVIII/XIX of the Social Security Act is true and correct.

Responsibility for Account – I understand that if my insurance benefits are insufficient to cover the cost of services, I am responsible for the remaining balance. I also understand that I am financially responsible for all services not covered by my insurance plan.

Collection Information – My portion of all charges is due at the time of service unless prior payment arrangements have been made. Any unpaid balance will be billed accordingly. Accounts with balances more than 90 days past due may be referred to a collection agency, and I understand that I am responsible for any associated collection costs. A $65.00 fee will be charged for any returned check or insufficient funds (NSF). If I do not have insurance, treatment options and costs will be discussed before services are provided, and payment arrangements may be established if necessary.

Attendance and Cancellation Policy – To achieve the greatest benefit from your treatment, it is important that you attend all scheduled appointments. We respectfully request at least 24 hours' notice for appointment cancellations. At our discretion, a $50.00 cancellation fee may be charged for cancellations made with less than 24 hours' notice, and a $50.00 no-show fee will be charged for missed appointments. Patients with more than three same-day cancellations or no-shows within a six-month period may be subject to scheduling restrictions or dismissal from the practice. Same-day appointments are reserved for urgent medical concerns at the provider's discretion. Non-urgent services, including routine callus care, do not qualify as same-day emergencies. We are committed to providing you with exceptional care and improving your quality of life.

Insurance Benefits – It is the patient's responsibility to contact their insurance carrier to verify coverage, including co-payments, co-insurance, deductibles, visit limitations, prior authorization requirements, and any expected out-of-pocket expenses before receiving services. The Member Services telephone number can typically be found on the back of your insurance card. While we are happy to submit claims as a courtesy, verification of benefits is not a guarantee of payment. By providing your insurance information, you acknowledge responsibility for all applicable co-payments, co-insurance, deductibles, non-covered services, and any balance determined by your insurance carrier. We are contractually obligated to file claims with your insurance carrier and collect any patient responsibility associated with your care. Please notify our office promptly of any changes to your insurance coverage.

Patient Payments and Charges – Please be prepared to pay any applicable co-payments, deductibles, or other patient balances at the time of each visit. Please note that outside facilities, including hospitals, laboratories, and pathology services, may bill you separately for services such as blood work, cultures, biopsies, or other testing. Thank you for taking the time to review our financial policies. We appreciate the opportunity to participate in your care. If you have any questions or concerns, please do not hesitate to ask.

Patient Signature: _____ **Date:** _____