RONALD VAN VLIET, DPM
CONSTANCE M. CAMARDA, DPM
1111 HIGHWAY 6 SUITE 255
SUGAR LAND, TX 77478
281-242-6202(FAX ALSO)
vvccfootdocs@windstream.net

WHERE DID YOU HEAR ABOUT US?_________________________

Patient Name _____________________________________ Birth Date___________ Age ____ M /F
Status: S M W D Social Security #______________________ Driver's Lic#________________
Address_______________________________________City______________State_____Zip_______
Home Phone (_____)_________________ Work Phone (_____)___________________
Employer: Name____
Address ___________________________________City________________State_____Zip_______

IF CHILD IS PATIENT, Parent/Guardian Name_______________________________________
Parent/Spouse Name ___________________________________ Birth Date______________
Social Security # ______________________________ Driver's Lic # _______________
Parent/Spouse Employer: Name____
Address _______________________________City________________State_____Zip_______

Medical Insurance: Yes___ No___ Medicare___ Medicaid___ Group___ Other____
Insurance Co. Name ____ Policy #_________________
Address ________________________________City________________State_____Zip______

<u>PERSON RESPONSIBLE FOR PAYMENT OF THE ACCOUNT</u>:

Name__________________________________Date of Birth__________ Relationship___________
Address_________________________________City_________________State_____Zip________
****
Briefly describe your foot problem____
____

Have you ever been treated for any of the following **conditions**:
Diabetes ____ High Blood Pressure ____ Difficulty Healing ____
Stomach Ulcer ____ Heart Problems ____ Kidney Problems ____
Rheumatic Fever ____ Bleeding Disorders ____ Liver Problems ____
Epilepsy ____ Other?_______________________________________

Are you presently taking any **medications**? Yes___ No___
If yes, what are you taking? ____

Have you ever experienced any **ALLERGIC REACTION** or had adverse side effects to:
Penicillin ____ Tape ____ Cortisone ____ Other Pain Medication? ______________
Aspirin ____ Anesthetics ____ Codeine ____ Other Antibiotics? __________________
Other Topical Preparations?___________
List any past **serious illnesses**: ____
List any past **operations**: ____
****

ALL CHARGES INCURRED ARE DUE AND PAYABLE AT THE TIME OF THE VISIT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

I hereby give my permission for the doctor to render the proposed Podiatric examination and treatment. I understand that I am financially responsible to the Physician for all charges incurred by my dependents, or me and further, I authorize the release of any medical information necessary to process any claim and request payment of insurance benefits due to be paid to the Physician supplying the service.

Signature ____ Date ________________
Patient/Insured

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- All patients must complete and sign our "Patient Information Form" before seeing the doctor.
- ALL PATIENTS ARE CHARGED FOR AN OFFICE VISIT, unless prior arrangements have been made.
- FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE unless prior arrangements have been made.
- WE ACCEPT CASH, CHECK, DISCOVER, AMERICAN EXPRESS, AND VISA/MASTERCARD.

ADULT PATIENTS

Adult patients are responsible for full payment at time of services.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, and his/her parents (or guardian), is responsible for full payment at time of service.

UNACCOMPANIED MINORS

Unaccompanied minors cannot receive treatment unless they have written consent which has been signed by the parent/guardian. The minor must be accompanied by parent/guardian for emergency treatment.
The parents/guardian are responsible for full payment.

REGARDING INSURANCE

As a service to our patients we will file with their insurance company. However, YOU ARE STILL RESPONSIBLE FOR ALL SERVICES.

We will accept insurance on the first visit provided insurance benefits can be verified prior to the scheduled appointment or at the time of service. If this cannot be done, full payment will be required at the time of service. If we accept your insurance, you may still be responsible for any deductible and coinsurance amounts which are not covered by your insurance.

If your insurance company has not paid on the FULL BALANCE within 45 days, you have 15 days to pay the outstanding balance. Late Payment Charges are added to unpaid accounts after 60 days from date of service. If your insurance company pays more than the balance due, we will send a refund check to you within 10 days.

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We are NOT a party to this contract, in most cases. (We will inform you if we are a party to your insurance contract, and will handle your claims according to our agreement with the insurance company, if one exists.) We will supply factual information as necessary, but we cannot become involved in disputes between you and your insurance company.

MEDICARE/MEDICAID/WORKER'S COMPENSATION

As participating Medicare providers, we can collect no more for any covered service other than what Medicare approves. However, since Medicare only pays 80% of what they approve, you are still responsible for the deductible, 20% coinsurance and any services performed which are not covered by Medicare.

We will accept Medicaid payments as payment in full except for services which are not covered by Medicaid. You are responsible for any services not covered by Medicaid.

In cases of financial hardship, Medicare makes certain allowances. Please let us know if this applies to you.

We will file on Worker's Compensation, however we must be able to verify coverage prior to the scheduled appointment or at the time of service.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

____ ____________________

Responsible Party Signature Date