Howard A. Staley, D.P.M. 611 Carthage Street Sanford NC 27330
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REGISTRATION

Patient's Name _____ Date _____
Present Address _____
City _____ County_____ State_____ Zip_____
Telephone _____ email (optional) _____
Date of Birth _____
Name of Parent (If Minor)_____
Billing Address (If Different)_____
Who is responsible for charges? _____
How will you pay for your portion of today's visit? Cash ☐ Check ☐ Visa/MasterCard ☐
Occupation _____ Employer_____ Telephone _____
Whom should we contact in case of emergency?_____
_____ Telephone:_____
What source did you find us? Physician Referral ☐ Yellow Pages ☐ Patient Referral ☐ Insurance Directory ☐
Website ☐ Other: _____
Please describe your most important foot problem _____
_____

MEDICAL HISTORY

Name of Primary Physician: _____
Address: _____
Date of Last Visit: _____May we send a letter to your doctor? Yes ○ No ○
Are you now being treated for any medical condition such as ?:
Diabetes ☐ High Blood Pressure ☐ Stomach ulcers ☐ Arthritis ☐
Anemia ☐ Heart conditions ☐ Depression ☐ HIV ☐
Other: _____
What medications are you now taking? _____
_____
Do you have any allergies to: (Please Check If Yes)
Adhesive Tape ☐ Aspirin ☐ Iodine ☐ Penicillin ☐ Other Antibiotics ☐ Latex ☐
Local Anesthetics ☐ (eg. Novocaine, Xylocaine) Sulfa Drugs ☐ Tetanus Toxoid ☐ Narcotics ☐
Other Allergies: (Specify) _____
Do you use tobacco? Frequent ○ Seldom ○ None ○ Do you use alcohol? Frequent ○ Seldom ○ None ○
Have you ever had: (Please Check If Yes)
Rheumatic Fever ☐ Stroke ☐ Heart Attack ☐ Hepatitis ☐ Phlebitis ☐
Do you have low back pain? _____
Have you had any previous surgery? If so, what and date of surgery, especially foot surgery:
_____

PLEASE PRESENT YOUR CURRENT INSURANCE CARD AND PHOTO ID TO THE RECEPTIONIST AT EACH VISIT

FINANCIAL POLICY AND AGREEMENT

Insurance may be accepted only as a courtesy. You are responsible for the unpaid portion of the bill. If your insurance has not paid within 60 days, you will be responsible for the entire amount. We do not assume liability for disputed or denied claims, and you must settle this with your insurance company yourself. Insurance over-payments of less than $5.00 will be maintained as a credit balance unless a refund is requested.

I agree to be financially responsible for charges incurred during the course of my treatment. I agree to remit the entire balance due upon presentation of an invoice. I also agree to pay cost of collection of services, including reasonable attorney fees, if I do not pay timely as required.

If my insurance policy requires a referral and/or prior authorization, and if I do not follow these guidelines, I understand and agree that no insurance payments will be applicable, and that I authorize services to be performed, and I will be responsible for all charges.

I authorize the release of any medical information necessary to process this claim and request payment of Medicare or insurance benefits to myself or to the party who accepts assignments below.
I authorize payment of medical benefits to First Feet, PLLC and Dr. Howard A. Staley for services performed.

IMPORTANT : Medicare and Medicaid, as well as most private insurance, does not usually pay for "Routine Foot Care" (trimming corns and/or toenails) and will be considered "NOT MEDICALLY NECESSARY". I authorize Dr. Staley to provide these services, if requested, and I am to be responsible for the charges, regardless of Medicare and Medicaid determination.

Except as noted by my writing "Declined" on the applicable paragraph and initialing (Exceptions will normally not allow us to accept you as a patient).

Signed and Agreed to:_____Date_____

NEW PATIENTS: A valid form of picture identification is requested at the first visit.

PLEASE PRESENT THE MOST RECENT AND VALID INSURANCE CARD FOR YOUR POLICY AT EACH VISIT MORE THAN 1 MONTH APART. PRESENTATION OF AN INVALID INSURANCE CARD WILL RESULT IN DENIAL OF CLAIMS, AS WELL AS ADDITIONAL FEES DUE TO PROCESSING COSTS, AND POSSIBLE PROSECUTION BY THE AFFECTED INSURANCE COMPANY. ALL FEE REDUCTIONS WILL ALSO BE VOIDED AND FULL AND IMMEDIATE PAYMENT FROM THE PATIENT IS EXPECTED.

APOLOGY: Dr. Staley and his employees do not like all of these rules and disclaimers. However, accepting insurance assignment is, in effect, issuing credit to persons otherwise unknown to us. Inadequate reimbursement from the insurance market forces us to collect all amounts allowed and not paid by insurance. We must pursue patient balances diligently.

FINANCIAL ASSISTANCE: Dr. Staley considers providing financial assistance, when needed, for urgent medical procedures. This must be requested **before** services are provided. Adequate proof of hardship may be requested. Children will always be seen for an examination regardless of the parents ability to pay.