DONAHUE FOOT AND ANKLE CENTER INC

PATIENT REGISTRATION

Patient Name _____ Male ☐ Female ☐ Birthdate_____
(Print)

Address _____Apt #_____ City _____ State ____ Zip _____

Home Phone (____) ____-_____ Cell Phone (____) ____-_____ Work Phone (____) ____-_____ SSN ___-___-____

Marital Status: ☐ Married ☐Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered

Employer/School: _____ Occupation: _____

Preferred Language: _____ Email Address: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Not Specified

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Not Specified

May we leave a message at your home or with residents? ☐ Yes ☐ No On your answering machine/voicemail? ☐ Yes ☐ No

Whom may we thank for referring you? _____

Person we may talk to about your medical concerns: _____ Relationship _____Phone: _____

Is this contact only for emergency purposes only? ☐ Yes ☐ No, they can be contacted regularly about my care

For minors only: Child lives ☐ with both parents ☐ Mother ☐ Father ☐Emancipated Minor ☐ Other
Parent/Guardian _____Address (if different) _____
Date of Birth: _____ Home Phone (____) _____-_____Work Phone (____) ____-_____
Responsible Party for insurance and bills: ☐ Patient ☐ Spouse ☐ Parents ☐ Mother ☐ Father ☐ Other _____

Primary Insurance Company: _____ Name on Contract: _____
Contract ID # _____ Group # _____ DOB _____
Relationship to cardholder: ☐ Self ☐ Spouse ☐ Dependent Card Copied ☐ Yes ☐ No Co-payment: $ _____
Secondary Insurance Company: _____ Name on Contract: _____
Contract ID # _____ Group # _____ DOB _____
Relationship to cardholder: ☐ Self ☐ Spouse ☐ Dependent Card Copied ☐ Yes ☐ No Co-payment: $ _____

Identification of other physicians/health care entities involved with my medical whom I authorize ongoing release of information for continuity of care:
Primary Care Physician: _____ Phone (____) ____-_____
Address: _____ Zip _____
Other Physician: _____ Phone (____) ____-_____
Specialty: _____

Pharmacy Name: _____ Address: _____Zip _____
Pharmacy Phone: _____

Signature: _____ Date: _____

Information reviewed: _____/11 _____/12 _____/13_____/14_____/15_____/16_____/17_____/18 _____/19

Statement of Assignment of Benefits, Financial Responsibility, Consent for Purposes of Treatment, Payment and Healthcare Operations,

Authorization for Use or Disclosure of Protected health Information

Assignment of Benefits

I hereby assign any/all medical and/or surgical benefits to which I am entitled through Medicare, Medicaid, Workers' Compensation or any other governmental or private insurance or health plans to the **Donahue Foot and Ankle Center, Inc., (DFAC), 3731 Pearl Road, Cleveland, Ohio 44109.** This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original.

Financial Responsibility

I understand that I am responsible for all charges, whether or not I have insurance. In the event that I have insurance with a plan that has a participation agreement with DFAC I understand that I am responsible for all deductibles, co-payments and co-insurances. In the event that I do not have insurance with a plan that has a participation agreement with DFAC, I understand that I am responsible for the full difference between DFAC billed charges and any amount paid by insurance.

Consent to Use Protected Health Information for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by DFAC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of DFAC. I understand that diagnosis or treatment of me by DFAC may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at:

Our Privacy Contact may be contacted at 216-459-8616
Donahue Foot and Ankle Center, Inc.
3731 Pearl Road
Cleveland, OH 44109

I understand that a revocation is not effective to the extent that my physician has relied on the use of disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative _____ Date _____

Print Name of Patient or Personal Representative _____ Description of Personal Representative's Authority _____