Chart #: ____________	DR. ERTZ DR. HAVENS
Today's Date: ____/____/2021	

Office use only

Southside Foot Clinics of Shreveport-Bossier

Patient's Name: ______________________________ Date of Birth:__/__/__
Sex: M__ F__ Soc. Sec. # ____-____-____
Primary Phone #: ( )______________ Other Phone #: ( )______________
Mailing Address:____
City: __________________________ State:________ Zip Code:________
Email Address:____
Employer: _______________________ Business Phone #: ( )__________
Emergency Contact:___________________ Phone #: ( )__________
Who may we thank for referring you: ________________________________
What brings you in today:______________________________________

MEDICAL INFORMATION

Primary Physician: ______________________ Last seen:________________
Diabetic: YES NO if yes, medication taken: __________________
High Blood pressure: YES NO if yes, medication taken:______________
Other Medications Taken:_______________________________________
____
Any Allergies:____
Major Surgeries in the past 5 years:_______________________________
____

Please Read and Sign:

I hereby authorize the release of any information necessary to complete and process my insurance claims during the period of medical care.Payment of the office visit charge is expected on your first visit. I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. Although I have requested the doctor to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill. I also understand and readily agree that if I suspend or terminate my care and treatment, and fees for professional services rendered to me will be immediately due and payable.

Patient's Signature:______________________________ Date:________
Responsible Party's Signature______________________________ Date:________

Consent for Release of Medical Records

Our clinic cannot release any medical information without your permission.

I, ______________________________do NOT wish to release any of my medical records.
Patients Name (PLEASE SIGN THE BOTTOM OF THIS FORM)

List a family member or friend who may contact us.

I authorize Southside Foot Clinic to release the information checked above pertaining to my personal medical records to____.
check the ones that will apply:

- Appointment Information ____
- Lab results _____
- Billing information _____
- Any other known records _____

If you would like to give your primary Dr access to your medical records please check the ones that will apply :

- Appointment Information ____
- Lab results _____

I authorize Southside Foot Clinic to release the information checked above pertaining to my personal medical records to the office of DR.______________________________________.

Patient signature: ____Date:__________________

Acknowledgement of general office policies

Our goal is to provide a good physician- patient relationship. Letting you know in advance of our office policy allows for a clearer communication lessening any future misunderstanding. Please read each section and initial you understand. If you have any questions, do not hesitate to ask a member of our staff.

Insurance plans:

1. It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
2. It is your responsibility to know if a written referral or authorization is required to see a specialist.

Initial:______________

Financial Responsibility:

1. According to your insurance plan, you are responsible for any and all copayments, deductibles and coinsurances.
2. **Copayments are due at the time of services.**
3. Self-pay patients are expected to pay for services in FULL at the time of the visit.
4. Patient balances are printed on the 1st of each month on the receipt of your insurance plan's EOB. Your remittance is due within 10 business days of your receipt of your bill
5. Any balances outstanding longer than 30 days may be sent to a collection agency.

Initial:______________

Privacy Practices:

Please read over our privacy policy on the back of the clipboard. If you would like your own copy for your records please let us know.

Initial:______________

Patient Signature:____ **Date:**____________________