

Chart #: _____
 DR. ERTZ DR. HAVENS
 Today's Date: ____ / ____ / ____
 southsideclinic@yahoo.com



Southside Foot Clinics of Shreveport-Bossier

Patient's Name: _____ **Date of Birth:** ____/____/____
Gender: M ___ F ___ **Soc. Sec. #** ____ - ____ - ____ (needed for insurance purposes)
Primary Phone #: _____ **Other Phone #:** _____
Mailing Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Email Address: _____
Employer: _____ **Business Phone #:** _____
Emergency Contact: _____ **Phone:** _____
Relation: _____
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: _____ **Last A1C:** _____
High Blood pressure: YES NO if yes, medication taken: _____
Other Medications Taken: _____

Any Allergies: _____
Major Surgeries in the past 5 years: _____

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, fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ **Date:** _____

Please turn to the next page to initial and sign



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:

Initial: _____

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.
3. It is your responsibility to know if your insurance is in **network** with our office.

Financial Responsibility:

Initial: _____

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.

I understand that my copay/deductible is an estimate only and that there is no way of knowing exactly what my insurance company will or will not pay. I understand that I am ultimately responsible for any unpaid balance, regardless of any insurance I may or may not have.

Initial: _____

Privacy Practices:

Initial: _____

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.

Cancellation/ No Show Policy for Doctor Appointment:

Initial: _____

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you could be charged a \$25 fee; **this will not be covered by your insurance company.**

We understand that delays can happen, however we must try to keep the other patients and doctors on time.

If a patient is late and does not call prior, it is up to the Doctor's discretion to reschedule the appointment.

Patient Signature: _____ Date: _____

Please note that refusal to sign the required office policy paperwork will result in cancellation of the appointment.