Charles T. Murphy, DPM

Podiatric Medicine and Surgery

Patient Registration

Patient Name:_____ **Responsible Party Name:**_____

Billing Address: _____ **City, State, Zip:**_____

Permanent Address:_____ **City, State, Zip:**_____

Home Phone: ( )_____ **Cell Phone: ( )**_____ **Work Phone: ( )**_____

Sex: M F Birth date: _____/_____/_____ **Age:** _____

Patient SS#: _____ **Marital Status:** *S M W D*

Responsible Party Name: _____ **Birth date:** _____

Responsible Party SS#: _____ **Relationship to patient:** *Spouse Parent Other*

Referring Physician or Referral Source:_____ **Phone:** _____

Primary Doctor & Phone: _____ **Date of Last Visit:** _____

Is patient: Employed: Y N Full Time Student: Y N Part time Student: Y N

Your Occupation: _____

Employer Name/Address/Phone: _____

Emergency Contact:_____ **Phone:** _____ **Relationship to pt:**_____

Person Responsible for this bill:_____ **Home phone:** _____

Address: _____

Responsible Party's Employer: _____ **Work Phone:** _____

Address: _____ **Occupation:**_____

How did you hear of our practice?

Friend/Relative:_____ **Physician:** _____

Phone Book:_____ **Web page:**_____ **Other:** _____

INSURANCE INFORMATION (PLEASE COMPLETE)

Primary Insurance Co. Name: _____

Insurance Co. Address: _____

Policyholder's Name: _____ **Birth date:** _____

Relationship to Patient: _____ **Policy holder Sex:** *M F*

Employer: _____

Policy #: _____ **Group #:** _____

Co-pay $ _____ **Deductible:** _____ **Verified:** _____

Secondary Insurance Co. Name: _____

Insurance Co. Address: _____

Policyholder's Name: _____ **Birth date:** _____

Relationship to Patient: _____ **Policy holder Sex:** *M F*

Employer: _____

Policy #: _____ **Group #:** _____

Co-pay $ _____ **Deductible:** _____ **Verified:** _____

AUTHORIZATION TO PAY

I hereby authorize payment directly to the business office of this physician for the surgical and/or medical benefits rendered to myself or to my dependents. I understand that I am responsible for any payment not covered by insurance.

Signature: _____ **Date:** _____

FINANCIAL POLICY

Thank you for choosing Dr. Murphy and his staff for your podiatry needs. Our primary goal is to provide the best care possible. We have some basic guidelines concerning insurance and financial requirements. These guidelines help us to control healthcare costs by reducing our billing and collection costs. Should you have any questions regarding our financial policy, please contact our office.

- **Insured patients-Co-pays are due at the time of service.**
- **Cash patients-payment is due at the time service is rendered.**
- **We accept *Cash, Check, MasterCard, Visa* and *Debit* for your convenience.**
- **There is a returned check fee of $25.00.**
- **Referrals: If you have an HMO or other managed care plan and are required to bring a referral, you must bring it with you on the date of your visit. If we do not receive the referral, you will be responsible for the charges. It is your responsibility to understand what your insurance company requires.**
- **If you are having financial troubles, please discuss them with our billing office. Please respect that we need to charge and get paid for the services we provide.**
- **Delinquent accounts will be turned over to the outside collection agency of our choice. Accounts are considered delinquent if unpaid after 90 days. In the event your account is turned over to collections, you will be required to pay this outstanding balance plus all applicable collection fees in full prior to resuming treatment with Dr. Murphy. Delinquent accounts are subject to dismissal.**

All Billing Inquires should be directed to (609)653-2066 Monday –Friday 9:00am-4:30pm

I have read and understand the financial policy of the office of Dr. Charles T. Murphy, DPM.

Patient/Guardian Signature:_____ **Date:**_____

Patient's Name:_____ **Date:**_____

Patient's Medical Information

Patient Name:_____ **Date:**_____

Reason for Visit:_____

How Long Have You Had This Problem?_____

_____

Have You Had Previous Treatment?_____

_____

Do You Have A History Of the Following?

- **Diabetes Yes No**
- **High Blood Pressure Yes No**
- **Heart Disease Yes No**
- **Bleeding Tendency Yes No**
- **Arthritis Yes No**
- **Gout Yes No**
- **Circulation problems Yes No**

Do You Smoke? Yes No If yes, how many packs per day?_____

Do You Have Any Other Medical Problems We Should Know About?_____

_____

_____

Have You Had Any Serious Illnesses or Operations?_____

_____

_____

Are You Taking Any Medications? Please list all medications, including over the counter meds._____

_____

_____

Do You Have Any Allergies?_____

_____

Current Height: _____ **Current Weight:** _____

Consent of Privacy Practices

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews.

I have been informed that I may review the practice's Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my personal health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restrictions.

I also understand that I may revoke this consent at any time by making a request in writing except for information already used or disclosed.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

List any names and relationships of those individuals (ex: family members) that you wish to give consent for our office to disclose information regarding your care:_____

_____