# MID NEBRASKA FOOT CLINIC

A STEP IN THE RIGHT DIRECTION

## Patient Registration Form

**Patient information**

| | | |
|---|---|---|
| Last Name: | First Name: | Social Security # |
| Date of Birth: | Sex: Female Male | Marital Status: D M S W |
| Street Address | City. | State: Zip: |
| Home #: | Cell #: | Work#: |
| Employer Name & Phone: | Email Address: | |
| Family Physician and Location: | Date last seen: | |
| Preferred Pharmacy Name and Location: | | |
| Emergency Contact Relationship, Name & Phone #: | | |
| How did you hear about Mid Nebraska Foot Clinic? | | |

**Additional Information and Responsible Party**

### Additional Information and Responsible Party

| | | |
|---|---|---|
| Person Responsible for the bill (ONLY IF DIFFERENT FROM PATIENT) : | | |
| Date of Birth: | Social Security #: | Phone #: |
| Street Address: | City: | State: Zip: |
| Is your visit today due to one of the following (please circle) : ACCIDENT AUTOMOBLIE ACCIDENT JOB RELATED ACCIDENT | DATE OF ACCIDENT: | |

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

| Race (please circle one): | Ethnicity (please circle) | Preferred Language: |
|---|---|---|
| White | Hispanic or Latino | English |
| Hispanic | Not Hispanic or Latino | Spanish |
| Other | Decline | Other: |
| Asian | | |
| American Indian or Alaska Native | | |
| Black or African American | | |
| Decline | | |

**Insurance Information**

### Insurance Information

| | |
|---|---|
| Ins. Co. Name | Policy Holder Name: |
| Policy Holder's Date of Birth | Policy Holder's Social Security #: |
| Patient Relationship to Policy Holder: | Secondary Insurance: |

The above information is true to the best of my knowledge. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign MNFC all money to which I am entitled for medical expenses related to the service performed from time to time by MNFC, but not to exceed my indebtedness to MNFC. I authorize any holder of medical information about me to release to CMS and agents any information needed to determine these benefits or the benefits payable for related services that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency.
MEDICARE Beneficiaries: I request that payment of authorized Medicare benefits be made to MNFC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient / Guardian Signature _____ Date _____

MID NEBRASKA FOOT CLINIC

A STEP IN THE RIGHT DIRECTION

**James E. Lewandowski DPM**

820 W Division St Grand Island NE 68801-6542 Phone: (308)381-4675 Fax: (308)381-4672

## PATIENT APPOINTMENT / NO SHOW POLICY

Mid Nebraska Foot clinic strives to provide quality care to our patients in the quickest manner possible, however because we have a limited number of appointment slots available each day it is very important that you for your show up scheduled visit at the time that you are scheduled. when scheduled patients do not show up for their appointments, we lose the opportunity to fill that time with a patient with acute healthcare needs. Therefore, we have implemented the following policy to best serve all of our patients:

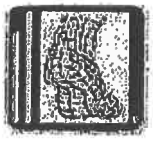
- If you arrive 10 to 15 minutes late you may be asked to reschedule to the next available appointment, which may be anywhere from 1-3 week.
- It is your responsibility to notify Mid Nebraska Foot Clinic if you are unable to keep a scheduled appointment.
- If you do not show up for a scheduled appointment without notifying Mid Nebraska Foot Clinic you will be charged a **$50.00 "NO SHOW FEE"** that will be due at your next appointment.
- If you have two consecutive "NO SHOW", you will be sent a letter, notifying you that you are in violation of the Mid Nebraska Foot Clinic "NO SHOW POLICY". After 3 "NO SHOW'S" we have the right to dismiss you as a patient.

Please be prompt for your appointments, Appointment times given to allow time for completion of necessary paperwork' If you arrive late for your appointment, you may be required to reschedule for another day.

By signing this policy, you acknowledge that you understand and agree to comply with the terms of this policy.

Patient Signature Date

Witness Signature Date



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## AGREEMENT/CONDITIONS OF TREATMENT

THIS IS AN AGREEMENT BETWEEN DR. LEWANDOWSKI AND MYSELF, SUMMARIZING OUR DISCUSSION AND UNDERSTANDING OF THE CONDITIONS UNDER WHICH WE MUTUALLY CONSENT TO TREAT MY FOOT/ANKLE PROBLEMS.

1. I UNDERSTAND that my physician, Dr. Lewandowski, will use his best skill and judgment to accomplish the desired result, but that Dr. Lewandowski, cannot and does not warrant or guarantee such result; also that his/her forecast of the length of time involved in therapy and/or recovery from surgery, the manner of recovery and the possible complications or untoward results is based upon the usual and average response in cases similar to mine, but that is not a promise, since my result/response may be different from the usual.

2. On my part, I PROMISE FULL COOPERATION WITH DR. LEWANDOWSKI AND HIS STAFF IN MY TREATMENT, whether by surgical or nonsurgical means. I understand that if I do not follow my doctor's instructions or the instructions of his/her staff concerning my care and treatment, including any necessary physical therapy, the outcome of my care and treatment could be put into jeopardy and a bad result may occur.

Patients or authorized person's signature: I authorize the release of any medical or other information necessary to process any Medicare claims. This also includes all other insurance coverages.

PATIENT'S SIGNATURE: _____ DATE: _____

# MID NEBRASKA FOOT CLINIC

A STEP IN THE RIGHT DIRECTION


## Dr. James E. Lewandowski DPM

820 W Division Street • Grand Island, NE 68801-6542
Phone: (308)381-7262 • Fax: (308)381-4672


## Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.

* Obtain payment from third-party payers.

* Conduct normal healthcare operations such as quality assessments and physician certifications.

*Specify uses and disclosures of protected health information (PHI) that require written patient authorization, such as marketing and fundraising.

*Include a statement of the right of the patient to be notified of an unauthorized disclosure of PHI.

*Inform patients that the practitioner must withhold information from an insurance company if the patient so requests and pays out of pocket in full for services.

I have received, read and understand your NOTICE OF PRIVACY PRACTICES containing a more complete description of the *uses* and disclosures of my health information. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

# MID NEBRASKA FOOT CLINIC

A STEP IN THE RIGHT DIRECTION

**Dr. James E. Lewandowski DPM**

820 W. Division Street ● Grand Island, NE 68801

Phone (308) 381-7262 ● Fax (308)381-4672

## AUTHORIZATION TO RELEASE INFORMATION FORM

Patient's Name: _____

Patient's Date of Birth: _____

Social Security Number: _____

I hereby authorize Mid Nebraska Foot Clinic to (check one): X Obtain from the following

X Release to the following

Name: _____

Address: _____

Phone Number: _____

The following documents/information from the records pertaining to services received

Date of Service: AS REQUESTED

The documents to be released are described or listed as: AS REQUESTED

_____

The records are required for the specific purpose of: AS REQUESTED

_____

I understand that my authorization will remain effective from the date of my signature until _____, and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.

I have read and understand the nature of this release.

_____ _____

Signature of Patient/ Patient's Designated Representative Date

_____ _____

Witness Date

# NOTICE TO ALL PATIENTS

Any item or service the doctor needs to use to treat your condition properly, if deemed not medically necessary, or if not covered by your insurance plan, will be something you will be billed for.

Our office is happy to assist you in any way we can by sending in and processing all claims we feel have a chance of being paid by your insurance.

There will be NO returns allowed on any piece of durable medical equipment, as reuse is prohibited by law.

We sincerely thank you for your patronage and look forward to serving all your foot care needs.

*Some items, such as ice wraps, shower protectors, lotions and other over the counter pharmaceuticals, are not sent to insurance as they are <u>not</u> covered by insurance and will have to be paid by the patient.

Mid Nebraska Foot Clinic
James E. Lewandowski, DPM

_____
Please initial here after reading

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**Dr. James E. Lewandowski DPM**
820 W. Division Street • Grand Island, NE 68801
Phone: (308)381-7262 • Fax: (308)381-4672

ATTENTION PATIENTS:

Any services deemed medically by the doctor, and not medically necessary by your insurance, will become the responsibility of the patient.

I have read the above statement and understand that I will be billed for any services deemed not medically necessary by your insurance.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

# MID NEBRASKA FOOT CLINIC

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**Dr. James E. Lewandowski DPM**
**820 W. Division Street • Grand Island, NE 68801**
**Phone: (308)381-7262 • Fax: (308)381-4672**

ATTENTION PATIENTS:

Mid Nebraska Foot Clinic is a private practice and participates with the majority of insurance companies.

It is the patient's responsibility to make sure they are going to a in network provider not Mid Nebraska Foot Clinic.

By signing this form, you agree that you have contacted your insurance company and/or agree to pay how the claim is processed by your insurance company.

Thank you for your cooperation

Patient Signature _____ Date _____

Witness Signature _____ Date _____