REGISTRATION

MOUNT KISCO FOOT SPECIALISTS, PLLC

RICHARD A. BERLINER, D.P.M.
JILL M. BERKOWITZ-BERLINER, D.P.M.
344 East Main Street, Suite 206
Mount Kisco, NY 11549
Telephone: (914) 666-7367

Date___________________

Patient____
(last name) (first name) (initial)

Street Address____

City____________________________________ **State**_______________________ **Zip**___________________________________

Home Phone_________________________ **Work Phone**________________________ **Cell Phone**_________________________

Gender (circle one) __M __F Age____**Birth date**_______________________

Email____

Marital Status (circle one) __Single __Married __Partner __Widowed __Legally Separated __Divorced

Employers Name____PT/FT Occupation________________________________

Name of Primary Insurance____ Policy #_______________________________

Policy Holder____ Relationship to Patient__________________________________

Name of Secondary Insurance____ Policy #_______________________________

If under 18 years of age:

Parent Name____ Contact #______________________________________

In Case of emergency, who should be notified?_____________________________________ Phone #______________________

How did you learn of our practice?____

Patients Primary Language_______________________________________

Patient's Race: (circle all that apply) American Indian or Alaskan Native Asian Black or African American
Native Hawaiian or Other Pacific Islander White Decline to Answer

Patient's Ethnicity: (circle one) Hispanic or Latino Not Hispanic or Latino Decline to Answer

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with____________________________________ _________________________ and assign directly to
(Name of Insurance Company)
Dr. Berkowitz-Berliner or Dr. Berliner all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

PATIENT SIGNATURE____**DATE**_______________

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr._______________________ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT SIGNATURE____**DATE**_______________

Patient Name:

CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY

I understand that my medication history may be obtained utilizing an electronic information exchange and that is protected health may provide valuable information for my healthcare provider. I hereby authorize Mount Kisco Foot Specialist, PLLC to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

PATIENT SIGNATURE____ **DATE**_____________

HIPAA

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was offered or provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and that I understood the notice.

PATIENT SIGNATURE____ **DATE**_____________

If responsible party is someone other than the patient:

Print name ____________Relation to patient _________________Signature_______________ Date__________

Contact Preferences

Please let us know how you prefer to be contacted with medical information (i.e. test results)

TELEPHONE: OK to leave message with: Patient Only _____

Spouse/Partner/Parent _____

Anyone answering the phone/Answering Machine _____

MAIL: _____ **EMAIL**: _____ EMAIL ADDRESS: ____

The doctors may discuss medical condition/care with the patients:

Spouse/Partner _____ Parents _____ Children _____ Other _____

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR.

WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOU FILE.

*COPAYMENTS – By law we MUST collect your carrier designated copay. Please be prepared to pay that copay at each visit.

*NON CO-PAY PLANS – If your plan does not require a copay and we participate, we will accept the designated fee. You are responsible for any deductible and balance your plan indicates on their explanation of benefits.

*REFERRALS – If you plan requires a referral from you primary care physician. It is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUIRED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with the referral as soon as possible.

*NON PLAN PATIENTS – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Your itemized receipt should be attached to your insurance form and sent to your carrier, who will reimburse you directly.

*MEDICARE – We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

You are responsible for the timely payment of your account.

WE ACCEPT CASH, CHECKS, MASTER CARD, VISA, AMEX OR DISCOVER.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

PATIENT SIGNATURE____ **DATE**_____________