Dr. Janale Beckford DPM
Podiatric Surgeon

PATIENT REGISTRATION FORM

First Name:	Last Name:
Sex (circle): Male Female Non-binary	Date of Birth:
Age:	SS number:
Home Phone #:	Cellphone #:
Email:	Marital Status:
Home Address:	City:
State:	Zip Code:
Occupation:	Employer:
Emergency Contact Name:	Emergency Contact Phone:
Date:	How did you hear about us?

Primary Care Provider:

Name of Primary Care Provider: Address: Phone Number:
Date of last visit:

Insurance:

Primary Insurance Company Name:
Secondary Insurance Company Name:

What is the reason for your visit today?

_____
_____

On a scale of 1-10, how would you rate your pain? (1 being no pain and 10 unbearable pain):
1 2 3 4 5 6 7 8 9 10

How long has this bothered you?_____

What treatments have you tried and have they been effective?

_____

The pain quality is: burning constant dull sharp shooting throbbing tingling tearing

Other:_____

What makes the pain worse? Running Walking Standing Certain shoes Elevation Touching/Rubbing

Other:_____

Have you experienced any trauma or injury to the area?
_____

_____

Is this condition the result of an event at work? No Yes

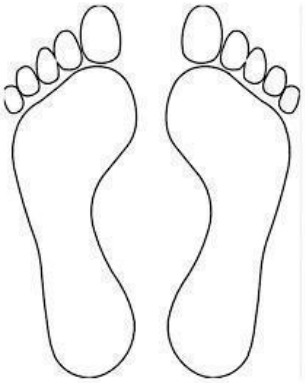
If yes, have you notified your employer and the worker's compensation liaison at your place of employment? Yes No

Please provide their contact information:
Name: _____ Phone #: _____

Please circle where on your feet/ankles you are having pain

LEFT RIGHT

LEFT RIGHT



LEFT RIGHT

Podiatric History:

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh and hip complaints.)
Athletic activities in which you participate: (Please list and indicate frequency)

Have you seen a Podiatrist before? (check one)	Yes:_____ No: _____
If yes, please list Name:	Date of Last Visit:
A personal family history of diabetes: (check one)	Yes: _____ No: _____
Cigarette/Tobacco use:	Years smoked:

Please indicate which foot problems now have or have had in the past below: (check Yes or No)	
Ankle Pain Yes:_____ No: _____	Athlete's Foot Yes: _____ No: _____
Bunions Yes:_____ No: _____	Corns/Calluses Yes:_____ No:_____
Numbness In feet/legs Yes:_____ No: _____	Flat feet Yes:_____ No: _____
Cramping in Feet/legs Yes:_____ No: _____	Heel Pain Yes: _____ No: _____
Ingrown Toenails Yes:_____ No:_____	Plantar warts Yes:_____ No: _____
Swelling of Ankles/feet Yes:_____ No:_____	Tired Foot Yes:_____ No: _____

MEDICAL HISTORY

Aids/HIV: ___Yes ___No	Epilepsy: ___Yes ___No	Rash: ___Yes ___No
High Blood Pressure: ___Yes ___No	Eye Problems: ___Yes ___No	Respiratory Disease: ___Yes ___No
Allergies to Medicine/ Drugs: ___Yes ___No	Fainting ___Yes ___No	Rheumatic Fever: ___Yes ___No
Anemia: ___Yes ___No	Foot Leg Cramps: ___Yes ___No	Shortness of Fever: ___Yes ___No
Angina: ___Yes ___No	Gout: ___Yes ___No	Sinus Problems: ___Yes ___No
Arthritis: ___Yes ___No	Headache: ___Yes ___No	Heart Disease: ___Yes ___No
Asthma: ___Yes ___No	Hemophilia: ___Yes ___No	Back Problems: ___Yes ___No
Bleeding Disorders: ___Yes ___No	Hepatitis or Jaundice: ___Yes ___No	Swollen Neck Glands: ___Yes ___No
Cancer: ___Yes ___No	Kidney Problems: ___Yes ___No	Tuberculosis: ___Yes ___No
Chemical Dependency: ___Yes ___No	Liver Disease: ___Yes ___No	Ulcers: ___Yes ___No
Chest Pain: ___Yes ___No	Low Blood Pressure: ___Yes ___No	Varicose Veins: ___Yes ___No
Chronic Pain: ___Yes ___No	Neuropathy: ___Yes ___No	Venereal Disease: ___Yes ___No
Circulatory Problems: ___Yes ___No	Phlebitis: ___Yes ___No	Unexplained Weight Loss: ___Yes ___No
Diabetes: ___Yes ___No	Psychiatric care: ___Yes ___No	Surgeries you have had:

Radiation Treatment: ___Yes ___No	Hospitalization - other than for surgeries listed:	Shoe size:
Are you now, or have been, under any other doctor's care for any other reason over the past two years? ___Yes ___No		If Yes, explain:

Include prescriptions, over-the-counter medications and vitamins with Dosage and Frequency

Pharmacy Name:_____

Pharmacy Phone:_____

Any Allergies to: Adhesive Tape, Anticoagulant Therapy, Aspirin, Codeine, Demerol, Iodine, Local Anesthesia, Novocaine, Penicillin, Seafood, or Sulfa? ____Yes ____No

List any other allergies:

_____

List and previous surgeries or hospitalizations (include number of miscarriages and live births):

_____

List of Current Medications:

DO YOU HAVE WHITE COAT SYNDROME (ELEVATED BLOOD PRESSURE, ANXIETY) WHEN YOU VISIT THE DOCTOR'S OFFICE? YES/NO

DO YOU HAVE A FEAR OF NEEDLES? YES/NO

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying Dr. Beckford and/or medical staff of any and all updates to the information listed above.

Patient signature:_____ Date:_____

Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have any questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsible party is responsible for their bill being paid in full. Please inform us at every visit of any changes to your insurance coverage.

Please initial each line indicating your understanding of our policies:

____**COPAYMENTS:** It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting the Doctor.

____**DEDUCTIBLES & CO-INSURANCE:** If you have a high deductible plan, we may collect a $100 deposit to apply towards your deductible & co-insurance. Any remaining balance due after submission to your insurance company is your responsibility.

____**SELF-PAY:** Full payment is due at the time of service. A down payment will be required before seeing the Doctor. At a minimum, an evaluation and management fee will be charged. Additional procedures/services may be recommended by the Doctor but you will be informed of these charges before proceeding with treatment.

____**REFERRAL:** If your insurance plan requires a referral from your Primary Care Doctor, this will be required at the time of your visit. Without a referral available, we may need to reschedule your appointment.

___**NO-SHOW:** 24 hours notice is required for cancellation of your appointment and failure to do so will incur a **$75** fee. Failure to provide 24 hours notice of a procedural visit will incur a **$100** fee.

____**SURGERY CANCELLATION:** Failure to provide 5 business days notice of cancellation prior to scheduled surgery date will incur a **$300** fee.

____**BALANCE/COLLECTION FEES:** If balance is not collected within 39 days from the postmark date of a mailed statement, a $12 re-billing fee will be added to each additional statement due to an unpaid balance. Accounts due more than 90 days will be turned over to our collection agency and a $35 administrative fee will be added. We accept cash, checks and all major credit cards.

____**FMLA/DISABILITY/MEDICAL RECORDS:** There is a **$25** charge for completion of these forms. There is a **$10** fee to obtain a copy of your medical records.

I have read and understand these financial policies.

Patient Name (Print)_____

Patient/Responsible Party Signature:_____ **Date:**_____

CONSENT FOR TREATMENT

I give my consent for necessary medical and surgical treatment and the use of anesthetics or any medications deemed necessary for my care.

PAYMENT OF SERVICES

Payment for services rendered is ultimately the patient's responsibility. Your insurance policy is a contract between you and your insurance company. It is YOUR responsibility to give us the correct information about your insurance company. You must comply with the rules of your insurance company such as obtaining a valid referral form. Plan eligibility for procedures does not always confirm certification, authorization or payment of service. We will file your insurance claim, but for claims denied because of failure to comply with the insurance company requirements, you will be responsible for paying the denied amount. For patient balances and self-pay accounts, we accept Cash, Visa, Mastercard, Discover, Care Credit and AMEX. In the event of non-payment, you will be responsible for any collection and/or legal fees associated with the collection of the outstanding balance.

MISSED APPOINTMENTS

Kindly give the office 24-hours notice if you are unable to make it to your appointment and book an alternative date and time. There is a 15-minute grace period for your arrival. After this time, it will be considered a No-Show and there will be a **$75** charge applied to your account. This $75 fee also applies to cancellations with less than 24-hours notice (with limited and specific exceptions).

CO-PAYMENTS AND DEDUCTIBLES

Your insurance company requires you to pay your copay at the time of service. Failure to pay is a violation of your contract with your insurance company. Please do not ask us to bill you for a co-pay. If you do not have your copay with you, we are happy to reschedule your appointment for the next available opening. The deductible amounts are always the patient's responsibility. Until the deductible is satisfied, your insurance is not responsible for reimbursement or payment. If you have $500 remaining of your deductible, we will require you to pay for any additional services at the time of your visit.

NON COVERED SERVICES

Not all insurance plans cover all services. In the event your insurance plan determines a service to be 'not covered', you will be responsible for the complete charge. We recognize government plans require an 'Advanced Beneficiary Notice' which we will provide.

TREATMENT PACKAGES

Specific treatment packages are available. These packages require a 50% deposit to secure your treatment, with the remaining 50% due on the day of treatment. The services and products offered in these treatment packages are non-refundable and ineligible for insurance billing due to their non covered nature.

PHYSICIAN NON-PARTICIPATION IN YOUR INSURANCE PLAN

We participate in numerous insurance plans. However, there are plans with which we do not participate and therefore you would be responsible for the difference between the "Out of Network" payment and our billed charges. If you have any questions, please contact your insurance provider.

I have read and understand the practice's Financial Policy and I agree to the terms.

Patient signature:_____ Date:_____

VIDEO TESTIMONIAL RELEASE CONSENT

Purpose of Consent: By signing this form (the "Release"), you are authorizing Dr. Janale Beckford, DPM PLLc ("Tampa Podiatrists and Wellness Center) to use and disclose your video testimonial I'm it's marketing and public relations efforts and acknowledge that the testimonial may be distributed to the media, other individuals and entities that may be involved in Dr. Janale Beckford, DPM marketing and public relations efforts and the public.

Right to Revoke: You have the right to revoke this Release at any time by giving us written notice of your revocation and submitting it to the Marketing Department at the address listed below. Please understand that revocation of this Release will not affect any action Dr Janale Beckford, DPM took in reliance on this Release before receiving your revocation.

CONSENT TO RELEASE

I hereby authorize Dr. Janale Beckford, DPM PLLc to copy, exhibit, publish, distribute or otherwise use and disclose my video testimonial and any information in the testimonial for purposes of publicizing its services and products, for any other marketing and public relations efforts or for any other lawful purpose. These statements may be used in printed publications, multimedia presentations, on websites or in any other distribution media. I understand and approve the disclosure by Dr. Beckford, DPM of testimonial information to the media, the public and other individuals and entities that may be involved in Dr. Beckford, DPM PLLc marketing and public relations efforts.

I agree that I will make no monetary or other claim against Dr. Janale Beckford, DPM PLLc for the use of the testimonial. I waive the right of prior approval for the use of my testimonial and hereby release Dr Beckford, DPM from all claims for damages of any kind based on the use of my video testimonial or information provided within the video testimonial. I understand that health information once disclosed may be re-disclosed by the recipient, and this re-disclosure May no longer be protected by federal law.

I understand that signing this Release is voluntary. My treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned upon signing this Release. I am at least 18 years of age and am competent to contract in my own name. I have read this Release before signing below and I fully understand the contents, meaning and impact of this Release.

This Release will expire five (5) years from the date that it is signed.

_____

_____

Signature Print Name

_____ Date

Please provide your contact information:

_____

Name

_____

_____

Address City, State and Zip code

_____ _____

Email Phone