



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 Breath or 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:

IF YOU HAVE ANSWERED YES TO ANY OF THE CONDITIONS ABOVE, PLEASE TELL US THE MONTH AND/OR YEAR OF DIAGNOSIS : _____

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