Patient Face Sheet

Please verify/provide all information.

Date: 1/10/2012

Dr Rick L Simon
231 E. Main St.
Lansdale, PA - 194468507
Phone: (215) 362 - 2220

Account Number: 0

Patient

Name (Last, First, Middle)	Social Security	Age	Birthdate	Sex	Marital Status

Street Address	Apt #	City	State	Zip Code

Home #	Cell #	Work #	Fax #	E-Mail

Responsible Party ☐ Same as Patient.

Name (Last, First, Middle)	Street Address	Apt #	City	State	Zip

Employer

Name	Address	City	State	Zip Code	Work Phone

Insurance

Primary Insurance	Policy # / Group #	Copay	Relationship	Subscriber Name

Subscriber BirthDate	Street Address	Apt #	City	State	Zip Code

Secondary Insurance	Policy # / Group #	Copay	Relationship	Subscriber Name

Subscriber BirthDate	Street Address	Apt #	City	State	Zip Code

Tertiary Insurance	Policy # / Group #	Copay	Relationship	Subscriber Name

Subscriber BirthDate	Street Address	Apt #	City	State	Zip Code

Emergency/Primary Contact

Name (First Middle, Last)	Relationship	Primary Contact Number	Secondary Contact Number

Primary Care Physician ☐ Contact Pysician for Health Records.

Name (First Middle. Last)	Address	Phone Number	Fax Number

Referring Physician ☐ Same as PCP.

Name (First Middle, Last)	Address	Phone Number	Fax Number

Patient Medical Information And Drug Allergies

Med Info	
Drug Aller	
Prev Surg	

Patient Release:
I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I agree that all balances owing to the provider will be paid by me.
I permit a copy of this release to be used in place of the original.

Signature: ______________________________ Date: ______________

CHART #________

PATIENT INFORMATION UPDATE
PLEASE PRINT

Name: ____

Street Address: ___________________________________ Apt #: ____________

City: ____________________________ State: _______ Zip code: ___________

Social Security #:__________________________ Date of Birth: _______________

Primary Care Physician: ____

Primary Pharmacy: ____

Pharmacy Address: ____

Preferred method of communication – please circle one

Email Phone Mail

Email Address: ____

Phone # (home) _______________________ (cell) __________________________

Current Insurance Information:

Primary: ____

Secondary: ____

Current – Weight: _________ Height: __________

Do You Smoke: yes____ no____ if yes, how many cigarettes per day ____________

Did You Ever Smoke: yes____ no____

Do you use any other form of tobacco: yes____ no____

Do you get a flu shot: yes_____ no_____

If yes have you received one yet this year: yes_____ no_____

Preferred Language – If not English – please specify __________________________

Ethnicity – please circle one

Non-Hispanic Hispanic

Race – please select one

_____ African or African American

_____ Asian or Asian American

_____ Caucasian or European American

______ Native American or Native Alaskan

______ Native Hawaiian or Other Pacific Islander

______ Other Race

PLEASE COMPLETE THE BACK SIDE OF THIS FORM

MEDICATIONS: Please list the name & dosage of all current medication you are taking – or ask receptionist to make a copy of your list if you have one

____
____
____
____
____
____
____
____

ALLERGIES:
____
____
____

MAJOR EVENTS, HOSPITALIZATIONS, SURGERIES, ETC: Please List
____
____
____
____
____

ONGOING MEDICAL PROBLEMS: Please List
____
____
____
____
____

FAMILY MEDICAL HISTORY
____
____
____
____
____

Office use only:

____________________________________ ________
Date Information entered into Practice Fusion First Name

Rick L. Simon D.P.M.
231 E Main St
Lansdale, Pa. 19446
(215) 362-2220

I give my permission for the staff of Dr. Simon's office to leave messages when they call to confirm my appointments etc.

____________________________________ __________________________
Patient Name (Please Print) Date

____________________________________ __________________________
Parent or Authorized Representative (if applicable)

____
Signature

Rick L. Simon D.P.M.
231 E. Main Street
Lansdale, PA 19446
(215)362-2220

________________________ ________________________
Patient's Name Insurance #

"I request that payment of authorized Insurance benefits be made either to me or on my behalf to Dr. Rick Simon, D.P.M. for services furnished to 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 to related services. I understand that I am ultimately responsible for my bill "

________________________ ________________________
Signature Date

- -

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

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

________________________ ________________________
Patient Name (Please print) Date

____
Parent or Authorized Representative (if applicable)

____
Signature

FINANCIAL POLICY

Patients with insurance coverage:
We will be glad to help you obtain the appropriate benefit from your insurance carrier and bill your carrier as a courtesy to you. However, you are responsible for the payments of the account.

Portions of the bill may not be paid by the insurance company and are to be paid by the patient. Sometimes there is a co-payment required by you as per your insurance agreement. Even if you have double coverage (this is possible if you and your spouse both have insurance), there may still be a portion that will be your responsibility.

If you have treatment over a period of time, we appreciate payment during the course of treatment. Our receptionist will assist you in arranging a payment schedule.

Concerning the Insurance Aetna, Dr. Simon is a provider with Aetna, however we are considered out –of-network for many plans. Therefore, if you decide to be treated and evaluated at this office you will be held.. RESPONSIBLE for all DEDUCTIBLES and COPAYS: that applies to your insurance, as well as any other. If you have any questions, please feel free to ask the office staff.

Patients without insurance coverage:
Patients without insurance coverage are requested to pay for services as rendered.

Additional Terms
Appointments cancelled with less than 24 hours notice are subject to a **$ 25.00** cancellation charge. Checks returned by your bank ae subject to a **$ 20.00** processing charge. Accounts unpaid after 30 days from the date of billing are subject to a finance charge at the rate of ½ % per month (6% per annum). If your account is referred for collection, you will be responsible for the collection costs in the amount of **40%** of the outstanding balance, together with court costs and reasonable attorney's fees.

We would like to take this opportunity to welcome you to our office and assure you that we will do our utmost to provide you with the best care possible.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF THE OFFICE OF DR. RICK SIMON.

X____ _____________________

SIGNATURE OF PATIENT OR GUARDIAN TODAY'S DATE