

REGISTRATION

MOUNT KISCO FOOT SPECIALISTS, PLLC

RICHARD A. BERLINER, D.P.M.
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359 East Main Street, Suite 2D
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Telephone: (914) 666-7367

Date _____

Patient _____
(last name) (first name) (initial)

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Sex M F Age _____ Birth date _____ Email _____

Social Security # _____ 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: American Indian or Alaskan Native Asian Black or African American
Native Hawaiian or Other Pacific Islander White

Patient's Ethnicity: Hispanic or Latino Not Hispanic or Latino

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.

Signature of Insured/Guardian

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.

Beneficiary Signature

Date

Patient Name: _____

HIPPA

Acknowledgement 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.

RESPONSIBLE PARTY SIGNATURE _____ DATE _____

If responsible party is someone other than the patient:

Print name _____ Relation to patient _____

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 your plan requires a referral from your 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.

RESPONSIBLE PARTY SIGNATURE _____ DATE _____