Heather Crawford, D.P.M. LLC
125 E. Main St. Unit 4D, Tuckerton, NJ 08087
(609)296-3533

Thank you for choosing Dr. Heather Crawford for your healthcare needs.

PLEASE NOTE:

PLEASE KINDLY ARRIVE ON TIME FOR YOUR APPOINTMENT !

PLEASE DO NOT HAVE ANY POLISH ON TOENAILS*

We look forward to your visit and hope we can be of continuing service. If you need to change or cancel your appointment, please do not hesitate to contact our office at (609) 296-3533

Failure to cancel an appointment could be subject to a "No Show Appointment" fee.

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PATIENT REGISTRATION

Last Name:_____ First Name:_____ Middle Initial:_____

Street Address:_____ City, State, Zip:_____

Home/Cell (circle one)Phone #: (_____) _____ - _____ Social Security #:_____

Date of Birth:_____ Age:_____ Sex:_____ Marital Status:_____

E-Mail:_____

Employer Name & Address:_____

_____Work Phone #: (_____) _____ - _____

Emergency Contact Name:_____

Relationship to patient:_____ Emergency Contact Phone #: (_____) _____ - _____

Please tell us how you heard about us:_____

GUARANTOR INFORMATION

Relationship of Guarantor to Patient: Self_____ Spouse_____ Parent_____ Other _____

Last Name:_____ First Name:_____ Middle Initial:_____

Street Address:_____ City, State, Zip:_____

Home Phone #: (_____) _____ - _____ Social Security #:_____

Date of Birth:_____ Age:_____ Sex:_____

Employer Name & Address:_____

_____ Work Phone #: (_____) _____ - _____

INSURANCE INFORMATION

Primary Insurance Plan:_____ Insured's Name:_____

Insured's Social Security #:_____ Insured's Date of Birth:_____

Policy/ID#:_____ Group #:_____ Copay:_____

Claim Address: _____

_____Provider Phone Number (_____) _____ - _____

Secondary Insurance Plan:_____ Insured's Name:_____

Insured's Social Security #:_____ Insured's Date of Birth:_____

Policy/ID#:_____ Group #:_____ Copay:_____

Claim Address: _____

_____Provider Phone Number (_____) _____ - _____

PLEASE DO NOT HAVE ANY POLISH ON TOE NAILS **MEDICAL HISTORY** ***PLEASE DO NOT HAVE ANY POLISH ON TOE NAILS***

Height: _____ Weight: _____ Are you pregnant: _____ How many months: _____

Reason for today's visit: _____

_____ **Duration of symptoms:** _____

Have you injured your foot? _____ How? _____

Please list any previous foot care/foot surgeries and approximate dates: _____

_____

_____

CHECK any that apply and please provide a comment and approximate date of diagnosis

	Asthma/Hay Fever				Kidney Disease	
	Diabetes				Bleeding Tendency	
	Thyroid Conditions				Low Back Pain	
	Gout				Psychiatric Disorder	
	Skin Conditions				Fainting Or Convulsions	
	Anemia				Strokes	
	Heart Problems				HIV Positive or AIDS	
	Poor Circulation				Scarring Tendency	
	High Blood Pressure				Numbness in Feet/ Legs	
	COPD				Do you smoke?	
	Liver Disease				Do you drink?	
	Stomach Problems				Do you use illegal drugs?	
	Arthritis				Other not listed	

Current Medications: _____

_____

_____

_____

Allergies:_____

Primary Care Physician/Family Doctor: _____

Phone #: (_____) _____ - _____ Fax #: (_____) _____ - _____

Last visit to physician: (This is needed to process Medicare claims) _____

Pharmacy: _____ Phone #: (_____) _____ - _____

Address_____

BILLING POLICY

I understand that the practice will file all claims for services rendered to my insurance carrier for your primary insurance plan. **Copays** are due at time of your appointment and there are no exceptions to this. We accept most insurances; however, **it is your responsibility to ensure we participate with your plan.** You must present your current active insurance card(s) at the time of your visit. **We do not back bill**.

It is ultimately the patient's responsibility to understand their health insurance coverage.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including private insurance and all other health plans to: **Heather Crawford, D.P.M.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I acknowledge that I am responsible for any balances that may be due to Heather Crawford, D.P.M. due to any/all of the following:

- Co-insurance, copays and yearly deductibles
- Non-covered services
- Out-of-Network charges
- Terminated coverage
- No insurance coverage
- No Referral obtained from primary care physician
- Failure to respond to insurance carrier correspondence (COB)
- Orthotics not covered or deemed "medically necessary" by insurance company
- **Failure to cancel an appointment/"no show" appointment fee of $50.00**

I understand that I will receive a statement for any balance due after my carrier has processed the claim. I understand and am agreeable that the balance of my statement will be paid in full to Heather Crawford, D.P.M. within thirty (30) days upon receipt. If I am unable to pay the entire amount I am responsible to **immediately**, upon receipt of the statement, call the office at 609-296-3533 to arrange a payment plan.

I understand that if I should pay by check to Heather Crawford, D.P.M. and the check is returned by the bank for non-sufficient funds, **I will be charged the amount of the check PLUS a $20.00 processing fee**. I also understand I will no longer be able to pay by check in the future.

Please Note: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not based on coverage by insurance companies.

Signature of Patient or Patient Legal Representative_____ **Date:**_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive. This notice will tell you about the ways we may use and share medical information about you. You may request a copy of this disclosure.

B. OUR LEGAL DUTY

Law requires us to:

- Keep your medical information private
- Give you this notice describing our legal duties and privacy practices, and your rights regarding your medical information
- Follow the terms of the notice that is now in effect

We have the right to:

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information we keep, including information previously created or received before the changes

Notice of Change to Privacy Practices:

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request

C. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

For treatment:

- We may use medical information about you to provide you with medical treatment or services
- We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you

For Payment:

- We may use and disclose your medical information for payment purposes

D. YOUR INDIVIDUAL RIGHTS

You have a right to:

1. Look at or get copies of your medical information
2. Request that we place additional restrictions on our use or disclosure of your medical information for purposes other than treatment or payment
3. You have the right to file a complaint with us about our privacy practices or our compliance with our **NOTICE OF PRIVACY PRACTICES.** We will investigate your complaint and give you our written answer. If you have questions, need more information or help to complete your complaint, please notify us.

Signature of Patient or Patient Legal Representative_____ **Date:**_____

I wish to be contacted in the following manner (Check All That Apply):

1. Home Telephone _____
   ___ Acceptable to leave message with detailed information
   ___ Leave message with call-back number only
2. Work Telephone _____
   ___ Acceptable to leave message with detailed information
   ___ Leave message with call-back number only
3. Written Communication
   ___ Acceptable to mail to my home address
   ___ Acceptable to mail to my work/office address
   ___ Acceptable to fax to this number _____
4. Other _____

I authorize the following person(s) to receive information regarding my medical condition(please include your doctors who may request information):

Name_____Relation_____

Name_____Relation_____

Name_____Relation_____

Name_____Relation_____

Name_____Relation_____

CONSENT FOR CARE

I hereby authorize and request Heather Crawford, D.P.M. to provide such medical care and administer such diagnostic and/or therapeutic procedures and treatments that are deemed to be medically necessary and advisable.

Print Patient Name:_____

Signature of Patient or Patient Legal Representative_____**Date:**_____