WELCOME TO THE TIMONIUM FOOT AND ANKLE CENTER

Jordan R. Stewart, D.P.M.
9622 Deereco Road
Timonium, MD 21093
410-560-2777

Date _____

Patient _____
Last name First name Middle Initial

Responsible Party/Guardian _____

Street Address _____ City _____State _____ Zip code _____

Home Phone _____ Cell Phone _____Email _____

Birth date _____ Age _____ Sex M _____ F _____ Single _____ Married _____ Widowed _____

Social Security # _____ Emergency _____ Contact Phone _____

Primary Language: English Spanish Other: _____ **Ethnicity**: Non-specified Non-hispanic or Latino Hispanic or Latino

Race: White Black or African American Asian American Indian or Alaska Native Native Hawaiian or Other Pacific Islander

Primary Care Physician _____ Date of Last Visit _____

Preferred Pharmacy _____

Who referred you or how did you hear about us? _____

Occupation _____ Employer _____Work Phone _____

PLEASE PROVIDE ALL INSURANCE CARDS TO THE RECEPTIONIST FOR COPYING
If policy holder is not the patient, please provide policy holder information below:
Name of Policy Holder _____ Relationship to Patient _____ Employer _____
Date of Birth _____ Contact Phone _____Social Security # _____

If this is a worker's compensation case, please provide the following information:
Claim # _____ Case manager_____ Case manager phone _____

AUTHORIZATION FOR TREATMENT, ASSIGNMENT, AND RELEASE
I hereby give Dr. Jordan Stewart and his staff permission to treat my foot and/or ankle disorder. I, the undersigned, have insurance coverage with _____ and assign directly to Dr. Jordan Stewart 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 Dr. Stewart 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 FOR TREATMENT, ASSIGNMENT, AND RELEASE
I hereby give Dr. Jordan Stewart and his staff permission to treat my foot and/or ankle disorder. I, the undersigned, request that payment of authorized Medicare benefits be assigned directly to Dr. Jordan Stewart for services furnished to me. I understand that by my signature, I request that payment be made and authorize the release of medical information necessary to pay the claim. If I have secondary insurance, my signature authorizes the release of all necessary information requested by the insurance company. 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 for deductibles, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier. I authorize the use of this signature on all my insurance submissions.

_____
Beneficiary Signature/Guardian Date

NOTICE OF PRIVACY PRACTICES, OFFICE PAYMENT POLICY, AND RELEASE OF MEDICAL INFORMATION
I acknowledge I have read and understand the Notice of Privacy Practices and a copy is available upon my request. I understand that unpaid balances 30 days over the invoice date will accrue 1.5% interest per month. I understand that a $5 reprocessing fee will be applied to each additional invoice issued on unpaid balances over 30 days. I understand that if I have an unpaid balance that is sent to collections, I am responsible for the unpaid balance, an additional 1/3 of the unpaid balance to cover attorney's fees, and all court fees. I hereby agree to waive the defense of statute of limitations as it pertains to any claim filed against me beyond three years after services were rendered. I understand that a $50 fee will be assessed on returned checks. I understand that a $50 fee will be assessed for missed appointments that are not cancelled or changed within 24 hours. I give Timonium Foot and Ankle Center permission to obtain and release medical information to referring physicians, insurance companies and attorneys requesting these records. I authorize the use of this signature for today's visit and all future visits. I acknowledge that I have read the office policies of the Timonium Foot and Ankle Center that are listed on the website at http:www.timoniumfootandankle.com/office-policies and are also available in our office.

_____
Patient Signature/Guardian Date

Timonium Foot and Ankle Center Office Policies

- **PAYMENTS DUE AT TIME OF SERVICE**

All Co-pay, Deductible and Co-Insurance amounts are due at the time of service. Benefits are checked in real-time to determine the status of deductibles and out-of-pocket maximums. In the event that claims process differently than anticipated, this may result in under collection or overpayment. If this occurs, our office will bill for balances or provide refunds per our refund policy.

- **CANCELLATION OR APPOINTMENT CHANGES**

A $50 fee will be charged for missed appointments **NOT** cancelled or changed within 24 hours of appointment.

- **RETURNED CHECK FEES**

A $50.00 fee will be assessed on returned checks.

- **MINORS**

Any patient under the age of 18 must be accompanied by an adult or they will not be seen.

- **NOTICE OF PRIVACY PRACTICE**

Available upon request.

- **REFUNDS**

Refunds are mailed from our bank. Refunds are issued once claims from all dates of service are finalized.

I acknowledge that I have read the office policies of the Timonium Foot and Ankle Center and I agree to comply with the office policies.

_____

First Name Last Name

_____

Patient/Guardian Signature Date