Bigfoot Podiatry, PLLC
Enrollment Form

www.bigfootpodiatrypllc.com
support@bigfootpodiatrypllc.com
P/360-616-9563 F/360-850-1423

Please return this form to our fax number, email or to the resident's facility.

Section A: Resident Information

Full Name: _____ Date of Birth: _____

Sex _____ Marital Status _____ Email Address _____

Address: _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____

Section B: Guarantor (Party responsible for health care authorizations and payment for care)

Full Name: _____ Relationship to Resident: _____

Address: _____

Email: _____ Phone Number: _____

Section C: Insurance and Other Payment (Please annotate one of the following)

Primary Insurance Information:

Insurance Carrier: _____ Policy holder's name: _____
Relationship to patient: _____ Policy holder's SSN: _____ DOB: _____

ID number: _____ Group Number: _____
Type of Insurance Plan: __ HMO __ PPO __ Medicare __ Medicaid __ Other: _____

Secondary Insurance Information:

Insurance Carrier: _____ Policy holder's name: _____
Relationship to patient: _____ Policy holder's SSN: _____ DOB: _____

ID number: _____ Group Number: _____

Type of Insurance Plan: ___ HMO ___ PPO ___ Medicare ___ Medicaid ___ Other: _____

Additional Medicare Information:

Are you enrolled in a Medicare HMO/PPO: ___ Yes ___ No Date: _____

Are you enrolled in: ___ Medicare Part A *or* ___ Medicare Part B (select all that apply)

For patients that do not have insurance, Bigfoot Podiatry, PLLC extends a discount to our published fee schedule that is consistent with the negotiated flat rate for the facility.

Section D: Acknowledgement, Affirmations, and Authorizations

1. I acknowledge that I have received a copy of Bigfoot Podiatry, PLLC's Notice of Health Information Privacy Practices (HIPAA) or that I have received said notice at www.bigfootpodiatrypllc.com.

2. I acknowledge and understand that I can discontinue service at any time and will not be charged for cancellations or appointments should a resident refuse treatment.

3. I affirm that I am authorized to coordinate the care for the resident identified in Section A. Furthermore, I affirm that I am responsible for payment on podiatric services rendered. Residents that qualify for Medicaid or Medicare will only be charged for services authorized by Medicaid or Medicare unless otherwise discussed with and consented by resident and/or POA. The guarantor identified in Section B is **not** financially liable for services that Medicaid or Medicare fails to cover.

4. I authorize Bigfoot Podiatry, PLLC to obtain medical records form the resident's care facility for the purpose of providing podiatric care. Bigfoot Podiatry, PLLC is authorized to request, record, and archive the resident's diagnoses, current medications, historical medications, and history of healthcare providers.

5. I authorize Bigfoot Podiatry, PLLC to obtain authorization for podiatric services from the resident's physician of record or from the facility's medical staff.

6. I authorize Bigfoot Podiatry, PLLC to contact me about the resident's foot and ankle care, the guarantor's billing preferences, and any issues surrounding insurance coverage.

Printed Name: _____ Date: _____

Signature: _____