

Ruth Ann Cooper, DPM

www.ruthanncooperdpm.com

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form completely.
If you have questions, we'll be glad to help you.

Patient Information

Name _____ Soc. Sec. _____
Last Name First Name Initial
Address _____ Home Phone () _____ Cell Phone () _____
City _____ State _____ Zip _____ Age _____ Date of Birth _____
Marital Status: () single () married () widowed () separated () divorce Gender: () Male () Female
Employer _____ Employer's Address _____
City _____ State _____ Zip _____ Work phone () _____
Family Physician/Pediatrician _____ Phone () _____

Insurance Information

▶ Primary Insurance

Primary Insurance Co. Name _____ ID # _____ Group # _____
Subscriber's Name _____ Soc. Sec. # _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Home Phone () _____ Relationship to patient _____ Employer _____

▶ Secondary Insurance

Primary Insurance Co. Name _____ ID # _____ Group # _____
Subscriber's Name _____ Soc. Sec. # _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Home Phone () _____ Relationship to patient _____ Employer _____

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Emergency Contact Information

Name _____ Relationship to patient _____
Last Name First Name Initial
Address _____ City _____ State _____ Zip _____
Home Phone () _____ Work phone () _____ Cell phone () _____

Allergies

List any allergies to MEDICATIONS: _____

List any other allergies: _____

Medications

List any medications with dosage and frequency: _____

Patient Contact Information

Any physician, staff, employee or representative of Ruth Ann Cooper, D.P.M. has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons.

All patients **MUST** fill in the following on who we can release information to or talk to by telephone, mail, etc.

Name & Relationship

Name & Relationship

Name & Relationship

Name & Relationship

Comments _____

Signature of Patient or Personal Representative

Date

() I do not want anyone to have access to my protected health information unless I provide explicit authorization.

Signature of Patient or Personal Representative

Date

RUTH ANN COOPER, DPM
4415B AICHOLTZ RD SUITE 200
CINCINNATI, OH 45245

PAYMENT AGREEMENT

Regardless of insurance benefits, or the designation of some other responsible party, I understand that I am financially responsible for the fees. If I am covered by Medicare, I understand that if I am provided specific written notice, in advance, that Medicare is not likely to cover a particular visit or procedure, I will be responsible to pay for that procedure or visit if I agree to proceed with that procedure or visit. Although the Practice will take reasonable steps to obtain reimbursement from the insurance company or the persons listed as being financially responsible, I agree that it is ultimately my responsibility to seek reimbursement for the medical bills from the insurance company, or the financially responsible party. Further, in the event of payment default, I agree to pay all collection costs in excess of the initial fee (including any legal expenses) and, at the option of the Practice, a reasonable charge for late payments.

All patients are responsible for having full knowledge of their health insurance requirements and restrictions. This includes gaining prior approval or referrals for office visits, procedures, surgery, etc. and communicating to our practice any hospital and/or lab restrictions. All patients must complete our patient information form and provide us with a current valid health insurance card along with a driver's license or photo identification that we may copy and keep in our files.

At the time of the visit, I understand it is my responsibility to obtain a current referral (if required) and pay any deductibles, co-payments, and/or coinsurance not covered by the insurance plan or a government program. Further, I authorize the Practice to file claims on my behalf for covered services and assign all insurance or other payor benefits to be paid directly to the doctor. I permit a copy of this authorization to be used in place of the original.

Ruth Ann Cooper, DPM does not treat Workers Compensation injuries nor do we file claims to workers compensation. By consenting to treatment in this office, you hereby declare that your condition is in no way related to a work injury. If after being treated by Dr Cooper, you reveal to us or your health insurance carrier that your treatment by Dr Cooper was for a work related injury, you will be personally responsible for full payment of all services provided to you by Dr Cooper regardless of insurance coverage.

I have read and understand this document and agree to its terms and conditions.

Patient/Parent/Guardian Signature: _____ Date: _____

RUTH ANN COOPER, DPM
4415B AICHOLTZ RD SUITE 200
CINCINNATI, OH 45245

Patient Consent for Use & Disclosure of Medical Information For Payment or Treatment

The Practice recognizes the importance of patient privacy. As such, it is the policy of this Practice to treat all medical information as confidential and absent extraordinary or emergency circumstances; the Practice will not disclose a patient's medical information without appropriate patient consent.

I, as the patient, or authorized representative of the patient, consent to the release of information regarding services rendered by the Practice to my insurance company or any governmental payor of the medical expenses as listed, or any other persons/entities as may be reasonably necessary for billing and collection purposes. I also consent to the release of medical information to my family physician and other treating physicians, as listed by me, as well as to any physicians to whom the Practice may refer me for purposes of further treatment. I consent to the use and/or release of medical information about me for purposes of health care operations, including quality assurance activities or other activities to review the Practice's treatment and services and to evaluate the performance of staff in caring for me. I consent to the Practice leaving a message on any answering device the Practice may reach when calling any telephone numbers I have provided, to confirm or change my appointment. In addition, if the patient is a minor child, I, as parent or guardian, consent to the release of medical information to the child's other parent, or the person(s) I have listed as being responsible for the medical bill. I understand that this consent to release information may include the release of personal and private medical information, if such release of information is necessary for reimbursement and billing purposes, or for purposes of subsequent treatment. Further, this consent is valid for the disclosure of medical information contained in hard copy or in electronic form, including, but not limited to, electronic mail ("email") and facsimile.

This consent to release medical information may be revoked in writing by me at any time and such revocation shall be effective immediately, except to the extent the Practice has taken action in reliance upon my consent.

I acknowledge that I was provided a copy of the Notice of Privacy Practices #001 and that I have read (or had an opportunity to read if I so choose) and understood this Notice.

Patient/Parent/Guardian Signature: _____ Date: _____