Richmond Foot and Ankle Clinic

36640 Heritage Dr   Richmond, MI 48062
Phone: (586) 727-7867   Fax: (586) 727-5598

Hengelberth D. Montufar, D.P.M, F.A.C.F.A.S.   Brandon C. Bultsma, D.P.M., A.A.C.F.A.S

PATIENT INFORMATION

PLEASE PRINT

LEGAL NAME:________________ ____ ________________ MALE:____ FEMALE:____
FIRST INITIAL LAST

ADDRESS:________________ ________________ ______ ______
NUMBER & STREET CITY STATE ZIP

PHONE NUMBERS: (   )________ (   )________ (   )________
HOME CELL WORK

MAILING ADDRESS (IF DIFFERENT):________ ________________ ______ ______
PO BOX CITY STATE ZIP

E-MAIL ADDRESS:________________________

DATE OF BIRTH:__________ PATIENT'S SOCIAL SECURITY NUMBER:________________

EMPLOYER:________________________ HOW DID YOU HEAR ABOUT OUR OFFICE:________________

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO

RACE: ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK/ AFRICAN AMERICAN/NATIVE ☐ HAWAIIAN ☐ WHITE/ CAUCASIAN ☐ MORE THAN ONE RACE ☐ OTHER PACIFIC ISLANDER

EMERGENCY CONTACT NAME:________________ PHONE:____________

PRIMARY PHYSICIAN:____________ ADDRESS:____________ PHONE:____________

PREFERRED PHARMACY:________________ PHARMACY CITY:________________

ALL INSURANCE INFORMATION MUST BE FILLED IN

PRIMARY INSURANCE CO:________________ CARDHOLDER NAME:________________

CARDHOLDER DATE OF BIRTH:________________ RELATIONSHIPT TO PATIENT:________________

CARDHOLDER EMPLOYER:__________ INSURANCE ID#:____________ GROUP#:__________

CARDHOLDER SOCIAL SECURITY NUMBER:________________

SECONDARY INSURANCE CO:________________ CARDHOLDER NAME:________________

CARDHOLDER DATE OF BIRTH:________________ RELATIONSHIPT TO PATIENT:________________

CARDHOLDER EMPLOYER:__________ INSURANCE ID#:____________ GROUP#:__________

CARDHOLDER SOCIAL SECURITY NUMBER:________________

PRINTED NAME OF PARENT OR GUARDIAN WHO BROUGHT MINOR IN:________________________

SIGNED NAME OF PARENT OR GUARDIAN WHO BROUGHT MINOR IN:________________________

VISIT RELATED TO A WORK INJURY: YES_____NO_____ AUTO INJURY: YES_____NO_____

IF WORK OR AUTO INJURY SEE RECEPTIONIST FOR ADDITIONAL PAPERWORK

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Consent to Treat

I give my permission to Dr. Hengelberth D. Montufar D.P.M. or Dr. Brandon C. Bultsma D.P.M. and assistants who participate with him to examine and treat my (or my dependent's) feet, hands, leg (below knee) and/or ankles.

Insurance Authorization

Please accept this form as a request of payment made directly to Hengelberth D. Montufar D.P.M. or Dr. Brandon C. Bultsma D.P.M. for any services furnished to me. Should there be any future questions regarding any claims, I authorize the release to my insurance company and its agents, any medical information needed to determine the benefits payable for related services.

Richmond Foot and Ankle Clinic will complete insurance forms and send them in on my behalf. The Richmond Foot and Ankle Clinic is the main billing office. I will be responsible for payment of any balances not covered by my insurance company, including deductable and copayments. Payment for services not covered will be made in a timely manner or financial charges will be assessed. These may include but not be limited to rebilling charges.

Medicare and Commercial Medicare Payment Authorization(when applicable)

I request that payment of authorized Medicare benefits be made to Hengelberth D. Montufar D.P.M. or Dr. Brandon C. Bultsma D.P.M. for any services furnished to me. I authorize the release of any medical information to the Healthcare Financing Administration and its agents needed to determine the benefits payable for related services

Date: ____________________

Patient Name Printed:_____________________________________

Guardian Name (if applicable) **Printed**________________________

Patient or Guardian Signature: ______________________________

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PATIENT HIPPA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (e.g. my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right too request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree with these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time, however, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date Signed:____

Patient Name Printed: ____

Gaurdian(if applicable) Name Printed:___________________________

Patient or Guardian Signature:_________________________________