

**Foot & Ankle Center of Tampa Bay**

**J. Russell Lowrey, D.P.M.**

Patient's Name: Last \_\_\_\_\_ M.I. \_\_\_\_\_ First \_\_\_\_\_

Address: Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Out of State Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Sex ( ) M ( ) F Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Marital Status S M D W

Primary Physician: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred by: (circle one) Friend Yellow Pages Seminar Doctor: Name \_\_\_\_\_ Other \_\_\_\_\_

**If Patient is a minor – Parent or Guardian, Please complete the following:**

Signature: \_\_\_\_\_ SS#: \_\_\_\_\_ Phone: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Work Address: \_\_\_\_\_

Is this a worker's compensation accident? ( ) Yes ( ) No

Is this visit a result of an injury or accident? ( ) Yes ( ) No

**Primary Insurance Company**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

I.D.#: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

**Secondary Insurance Company**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

I.D.#: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

Person to contact in case of an emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

I understand that medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. Please remember that insurance is considered a method of reimbursing the patient for the fee paid to the doctor and is not a substitute for payment by the patient. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance company.

Authorization: I authorize any holder of medical or insurance information to release this information to Dr. Lowrey or his billing agent. I permit a copy of this authorization to be used in place of the original. I also authorize the release of my medical records to other healthcare providers or insurance companies affecting my care. I understand that payment is due at the time of service unless other arrangements have been made. I request that payment for services furnished to me be paid directly to Dr. Lowrey. My signature acknowledges confirmation for authorization or assignment of Medicare or Private Insurance.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

FINANCIAL POLICIES FOR PODIATRIC SERVICES  
EFFECTIVE JULY 1, 2003

We want you to receive the best care possible and be totally satisfied with our service. Our experienced office staff will be happy to answer any question regarding your account. Here are some important points to remember regarding your care in our office.

1. To keep medical care and billing costs down, payment for services is due at the time services are rendered unless payment arrangements have been approved in advance IN WRITING by our office manager.
2. We are contract providers for Medicare and many private insurance plans. In those cases, we have agreed to accept their determination of fees for covered services. These payments are due at the time of service. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.
3. Not all services are a "covered" benefit in all insurance policies. Your policy is a contract between you and your insurance company. Medicare and some insurance companies select certain services that they will not cover. Payment for these services is the responsibility of you, the patient. We strongly encourage you to carefully read your insurance policy so that you will know the conditions and circumstances of your coverage.
4. Insurance companies may impose a waiting period before providing coverage and they may exclude coverage for what they determine to be "pre-existing conditions." They may also require that you obtain prior approval before treatment.
5. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 70% or 80%) of usual, customary and reasonable (UCR) for this region.
6. When we are able to verify your coverage and benefits in advance for Medicare and our approved private insurance plans, we will accept assignment of your insurance benefits and will bill the carrier directly. Accepting assignment means that your insurance company will send us the bulk of the payment for treatment and that you, the patient, pay us directly for the deductibles, co-payments and non-covered services and fees. In these circumstances, payment of your portion will be estimated at the time of services and must be paid at the time. When the insurance company does pay us, or at 45 days from the date of billing your insurance company, whichever occurs first (insurance companies are required by law to pay or deny claims, within 30 days), you will be responsible for any remaining balance or we will refund you any overpayment you have made. Our accepting assignment of your insurance benefits does not relieve you of your personal responsibility for prompt payment of the total bill. If your insurance company does not completely or promptly pay, you are responsible for paying the remaining balance immediately upon receipt of a bill. As a patient of this office, to expedite proper payment, we will complain to the Insurance Commissioner and/or Department of Corporations on your behalf regarding payment of claims.
7. Any account balance not paid in full within 60 days will be subject to a monthly finance charge of 1.5% per month (18% A.P.R) and a monthly cost of rebilling/account maintenance charge of \$5.00. These rates and charges are subject to change upon 30 days written notice. If any account balance should remain unpaid for 90 days and the Doctor refers the account to a collection agency or attorney, the responsible party is responsible for paying the costs of collection and that such fees and costs may be added to the account balance.
8. Payments will not be delayed or withheld, regardless of any lawsuits, liens, insurance coverage, the pendency of claims thereon or the outcome of medical treatment. All proceeds from the plan are assigned to the Doctor where applicable.
9. Requests for non-customary assistance such as special billing, rebilling, completion of forms and special reports and information requests are not included in our fees and will be billed separately. X-rays and charts are part of you permanent medical records in our office. Copies can be provided upon advance notice and payment of duplicating costs.
10. If your diagnosis or treatment involves others, such as hospitals or laboratories, you will be billed by these entities separately.
11. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.
12. Any exceptions to this agreement must be in writing and signed by your doctor.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# FOOT & ANKLE CENTER OF TAMPA BAY

**J. Russell Lowrey, D.P.M.**

Clearwater Office (727) 443-1559

Westchase Office (813) 855-3606

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

Reason for visit (Chief Complaint): \_\_\_\_\_

## **MEDICAL HISTORY:** (Check all that apply)

- Arthritis: Osteoarthritis / Rheumatoid
- Asthma
- Bleeding Disorder
- Blood Clots / DVT
- Cancer
- CHF / Congestive Heart Failure
- Diabetes: NIDDM      IDDM
- Heart Attack / Heart Condition
- High Blood Pressure (Hypertension)
- HIV / AIDS
- Liver Disease (Hepatitis)
- Kidney Disease
- Lung Disease
- Neuropathy / Nerve disorder
- Phlebitis
- Poor Circulation
- Rheumatic Fever
- Stomach Ulcers / GI Disorder
- Stroke
- Vascular Disease

Other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you have any of the following:

- |                 |                              |                             |
|-----------------|------------------------------|-----------------------------|
| Vascular Grafts | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Joint Implants  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pacemaker       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Valve     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**PAST SURGERY:** (Please list)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **MEDICATIONS:** (Please List)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you take a blood thinner:  Yes       No  
Do you drink alcohol:       Yes       No  
Do you smoke:  Yes       No      \_\_\_\_\_ packs/day

## **ALLERGIES:** (Check all that apply)

- NONE
- Aspirin
- Anti-inflammatory / NSAIDS
- Codeine
- Demerol
- Latex
- Local Anesthetic (Novocaine / Lidocaine)
- Penicillin
- Shrimp / Iodine / Betadine
- Sulfa

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Foot & Ankle Center of Tampa Bay**

**ACKNOWLEDGMENT OF RECEIPT  
OF  
NOTICE OF PRIVACY PRACTICES**

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

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)

\_\_\_\_\_  
Signature