600 N OLD WOODWARD AVE STE 202 | BIRMINGHAM MI, 48009 | (248) 594-3338

Written Financial Policy

Thank you for choosing Birmingham FootCare Specialists. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. For patients with insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment [2]. Any outstanding balances can be paid by the following payment options:

- Cash, Check, Visa®, MasterCard®, American Express®, Discover Card® or ApplePay
- Convenient Monthly Payment Plans[1] from CareCredit
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Birmingham Foot Care Specialists requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete.

We accept payment in thirds for treatments over $75.00. For plans requiring multiple appointments, alternative payment arrangements may be provided.

Please note, according to a Fraud Alert issued by the U.S. Department of Health and Human Services in 1998, it is against the law to waive deductible or co-insurance charges.

A fee of $60.00 is charged for patients who miss more than 2 appointments in a calendar year without 1-hour notice.

Birmingham Foot Care Specialists charges $35.00 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the treatment and care you want and need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 120 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier

BFCS

REASON FOR VISIT _____

_____

FIRST NAME_____ LAST NAME_____

HOME ADDRESS _____

CITY _____ STATE _____ZIP CODE _____

EMPLOYER _____ OCCUPATION _____

HOME # (____) _____-_____ CELL# (____) _____-_____ WORK# (____) _____-_____

EMAIL _____
(List email if you would like to register for online medical records access)

RELATIONSHIP STATUS: MARRIED SINGLE DIVORCED WIDOW(ER) OR OTHER

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD LIFE PARTNER

ARE YOU DIABETIC? Y OR N ***IF YES, ARE YOU INSULIN DEPENDENT? Y OR N

PRIMARY CARE PHYSICIAN NAME & PHONE NUMBER

_____

PHARMACY NAME & PHONE NUMBER

_____

EMERGENCY CONTACT:

NAME _____ RELATIONSHIP _____NUMBER_____

HOW DID YOU HEAR ABOUT US?

_____

PATIENT/GUARDIAN'S SIGNATURE **DATE**

BFCS

Peter E Schaffer, DPM

HISTORY

NAME: _____ DATE: _____
DOB: ____/____/_____ AGE: _____ GENDER: _____ MARITAL STATUS: _____
HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____ OCCUPATION: _____

HISTORY OF PRESENT ILLNESS

Condition seeking help for today: _____

Describe your symptoms: _____

_____

Is this condition: **CHRONIC / NEW INJURY / OCCURRED FOR NO APPARENT REASON**

Is this condition related to an accident or fall? Y or N

Can you relate it to any one incident? If yes, please describe _____

_____

INJURIES/FRACTURES: _____

PAST SURGICAL HISTORY: _____

OTHER ILLNESS: _____

DRUG ALLERGIES: _____

MEDICATIONS: _____

_____

(ATTACH A LIST OF MEDICATIONS, IF NECESSARY)

PAST MEDICAL HISTORY / FAMILY HISTORY

(-) HEART DISEASE _____
(-) HIGH BLOOD PRESSURE _____
(-) STROKE _____
(-) RHEUMATIC FEVER _____
(-) SCARLET FEVER _____
(-) KIDNEY DISEASE _____
(-) URINARY INFECTION _____
(-) LIVER DISEASE/ HEPATITIS _____
(-) EPILEPSY _____
(-) STOMACH ULCER _____
(-) THYROID DISEASE _____
(-) CANCER _____
(-) PREGNANCY _____
(-) COVID _____
(-) TOBACCO # PKS/DAY _____ # YRS_____

(-) ARTHRITIS _____
(-) GOUT _____
(-) DIABETES/SUGAR _____
(-) CIRCULATION DISEASE _____
(-) HARDING OF ARTERIES _____
(-) RAYNAUDS DISEASE _____
(-) VARICOSE VEINS _____
(-) NUMBNESS _____
(-) CRAMPING/COLDNESS _____
(-) ASTHMA _____
(-) TUBERCULOSIS _____
(-) PROLONGED BLEEDING _____
(-) ANEMIA _____
(-) HIV _____
(-) ALCOHOL _____

PLEASE INITIAL EACH LINE

_____YES, I WISH TO HAVE PETER SCHAFFER, DPM PROVIDE FOOT CARE AS NEEDED AND IN ACCORDANCE WITH ANY GUIDELINES SET FORTH BY THE INSURANCE COMPANY, IF APPLICABLE.

_____DUE TO THE MANY CHANGES IN INSURANCE POLICIES, IT IS NO LONGER AN EASY TASK TO INTERPRET EACH INDIVIDUAL POLICY ALTHOUGH WE TRY TO STAY AWARE OF THESE CHANGES, IT IS NOT ALWAYS POSSIBLE. THEREFORE, **WE URGE YOU**, AS THE PATIENT, TO PLEASE CHECK WITH YOUR INSURANCE COMPANY PRIOR TO ANY TREATMENT OR SURGERY. **IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL COVERAGE**. FAILURE TO COMPLY WITH THIS SUGGESTION COULD RESULT IN YOU, THE PATIENT, BEING RESPONSIBLE FOR ALL COSTS INCURRED. PLEASE REMEMBER YOUR INSURANCE POLICY IS BETWEEN YOU AND YOUR INSURANCE COMPANY AND NOT WITH THE INSURANCE COMPANY AND YOUR DOCTOR.

_____DR. SCHAFFER'S STAFF OR HIS AGENTS MAY CONTACT YOU BY TELEPHONE AT ANY TELEPHONE NUMBER ASSOCIATED WITH YOUR ACCOUNT, INCLUDING WIRELESS TELEPHONE NUMBERS, WHICH COULD RESULT IN CHARGES TO YOU. WE MAY ALSO CONTACT YOU BY SENDING TEXT MESSAGES OR E-MAILS, USING ANY EMAIL ADDRESS YOU PROVIDE TO USE. METHODS OF CONTACT MAY INCLUDE USING PRE-RECORDED/ARTIFICIAL VOICE MESSAGES AND/OR USE OF AN AUTOMATIC DIALING DEVICE, AS APPLICABLE. I HAVE READ THIS DISCLOSURE AND AGREE THAT BFCS MAY CONTACT ME/US AS DESCRIBED ABOVE.

_____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE

_____ _____

SIGNATURE OF WITNESS DATE

HIPAA Privacy Consent/Authorization Form

(Required by Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

PETER SCHAFFER, DPM
BIRMINGHAM FOOTCARE SPECIALISTS
600 N. OLD WOODWARD AVE, SUITE 202 BIRMINGHAM, MI 48009

Health Insurance Portability and Accountability Act requires that all medical provides, insurance companies and others, put in place controls to ensure that your personal medical information is safe.

Birmingham Footcare Specialists requests that each patient sign this consent form which allows us to share and protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected information about you. You have the right to review our notice before signing this consent.

Signature of Patient or Representative: _____ Date: _____

(PRINT) Name of Patient: _____Date of Birth: _____

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents, or others to call and request the results of tests and procedures. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results released to family members you must sign this form. Signing this form will only give consent to release laboratory and radiology results to the family members indicated below. This consent form will not allow Birmingham Footcare Specialists to release any other information to these family members.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Birmingham Footcare Specialists to release my laboratory/radiology results and reports to the following individuals:

1._____Relationship to patient: _____Date:_____
2._____Relationship to patient: _____Date: _____

PATIENT NAME: _____ PATIENT SIGNATURE: _____

Authorization to Leave with Household Members/Answering Machine

From time to time it is necessary for representatives of Birmingham Footcare Specialists to leave message for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab or procedure results, or to ask a patient to call BFCS regarding an issue or concern. At no time will a representative of BFCS discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave DETAILED messages with members of your household or on your answering machine.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name: _____
Patient Signature: _____ Date: _____