Welcome to our New Patients

Welcome to our practice! We appreciate the opportunity to be of service to you and hope that you will be pleased with our services.

Our practice is a division of the **InStride Foot & Ankle Specialists, PLLC**. We have divisions across North and South Carolina, and we operate under one tax id number. As such, if you have seen any of the following physicians in the past three years, we need to know so that we will not file a new patient code for your visit today. Since the insurance carriers look at us as one large practice, if you have been seen at any of the following divisions, you will not be considered a new patient in our practice. **Visits prior to 2013 do not need to be disclosed.**

Please review the names of the divisions and podiatrists below and indicate if you have been seen at any of these divisions by putting a ✓ on the line to the left of the practice name. Thank you for disclosing this information to us – it will allow us to be in compliance with nationally mandated correct coding initiatives.

	Division	Podiatrist
___	Alta Ridge Foot Specialists	Robert van Brederode, William Broyles, Thomas Verla
___	Ankle & Foot Center of Charlotte **(Resigned from group 7/1/2017)**	Scott Basinger
___	Brunswick Foot & Ankle Surgery, PA	Joseph Kibler
___	Carmel Foot Specialists	Barbara Kaiser, Richard Lind, Richard Miller, Kevin Molan, Tori Simmons-Lewis
___	Carolina Foot & Ankle Health Center	Millicent Brown
___	Carolina Foot Care Associates, PLLC	Ashma Davidson, Terry Donovan, William O'Neill
___	Carolina Podiatry Group	Brandon Percival, Julie Percival, William Harris
___	Central Carolina Foot & Ankle Associates	Melissa Hill, Gary Liao, Alan Sotelo, Phil Ward (retired), John Iredale (retired)
___	Chapel Hill Foot & Ankle Associates, P.A.	Jane Andersen, Alan Bocko, Katherine Williams
___	Charlotte Foot & Ankle Specialists, PLLC **(resigned from group 8/1/2017**	Kristine Strauss
___	Coastal Carolina Foot & Ankle	Thomas Hagan, Tyler Hagan
___	Comprehensive Foot & Ankle Center, P.A.	Zack Nellas
___	Crystal Coast Podiatry	Thomas Bobrowski
___	Eastover Foot & Ankle, P.A. **(Resigned from Group 1/1/17)**	Chris Fuesy, Ron Futerman, Kent Picklesimer
___	Family Foot & Ankle Center, P.A.	Patrick Dougherty, Doug Smith
___	Family Foot Care	Kevin McDonald
___	Foot & Ankle Center of Durham	Eric Simmons
___	Foot & Ankle of the Carolinas, PLLC	Eric Ward, Blaise Woeste
___	Gaston Foot & Ankle Associates, P.A.	David Kirlin, Ryan Meredith, Wagner Santiago, **Randell Contento (7/1/2017)**
___	Greensboro Podiatry Associates, P.A.	Martha Ajlouny, N'Tuma Jah
___	Hendersonville Podiatry	Russ Barone, Pam Stover
___	James Mazur, D.P.M., P.A.	James Mazur
___	Kinston Podiatry	Dale Delaney
___	Matthews Foot Care	Brian Killian, Kevin Killian, David Ellenbogen
___	Mt. Airy Foot & Ankle Center, PLLC	Jim Shipley
___	Myers Podiatric Clinic	William Myers
___	Piedmont Foot & Ankle Clinic	Rick Hauser, Rob Lenfestey (retired), Jason Nolan, Joel Kelly, Elizabeth Bass Daughtry, Jacob Panici
___	Piedmont Podiatry Associates	Subodh Choudhary, Nicholas Canoutas, Cassandra Pike, Sarah Fitzgerald, Smitha Jospeph (retired)
___	Queen City Foot & Ankle Specialists, P.C.	Roxanne Burgess, Alison Garten
___	Raleigh Foot & Ankle	Alan Boehm, Robert Hatcher, Jordan Meyers, Kirk Woelffer
___	Ryan Foot & Ankle Clinic	David Garchar, Jeff Glaser, Michael Ryan, Scott Whitman, Matthew Borns
___	Salem Foot Care	Walter Falardeau, Scott Matthews
___	Summit Podiatry (Starting 5/1/2017)	Derek Pantiel
___	Upstate Foot Care	Hans Blaakman
___	Wake Foot & Ankle Center	Mike Hodos, Jim Judge
___	Wilson Podiatry Associates, PA	Kendall Blackwell

___ I attest that I have been seen in the above indicated division of the InStride since 01/01/2013.

___ I attest that to my best recollection, I have not been seen by any of the above divisions/physicians since 01/01/2013.

Signature of patient: ______________________________________ Date: ______________

Printed Name: ____ DOB: ______________

Financial Policy

Thank you for choosing Instride Foot and Ankle Clinic, Dr. James Mazur as your health care provider. We are committed to building a successful physician-patient relationship with you. A clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.)

Co-pays

Tha patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at the time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. No post-dated checks will be accepted.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Participating Insurances:

AETNA HMO, PPO, POS, Medicare Advantage

Blue Cross and Blue Shield of NC HMO, PPO, POS, Blue Medicare, Blue Local Blue Advantage & Blue Select Exchange Plans NOT Blue Value Exchange Plans

Cigna HMO, PPO, POS (NO MCR ADV at this time)

CorVel Workers Comp PPO

Humana HMO, PPO, POS, Medicare Advantage

Medcost PPO, Inclusive Health

Tricare Plans All plans except Tricare Prime

Primary Physicians Care PPO

United Healthcare HMO, PPO, POS, ALL Medicare Advantage such as Secure Horizons, EverCare, Pacificare UHC Exchange Products

Participating Insurances

If your insurance plan is one with we are not a participating provider, you will be responsible for payment in full. However, as a courtesy, we will file your initial insurance claim and if not paid within 30 days you will be responsible.

Referrals and Preauthorizations

Certain health insurance (HMO, POS, etc.) require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

Self-pay Accounts

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts.

Motor Vehicle Accident (MVA) and Third-Party Billing

We do not do any third party billing. Our relationship is with you and not with the third-party liability insurance (auto, homeowner, etc.) It is your responsibility to seek reimbursement from them. However, at your request, we will submit a claim to your primary health insurance carrier. You may receive an accident questionnaire from them to be completed by you. If the questionnaire is not returned to your medical insurance company and/or we receive a denial on your claim, you will be responsible for payment in full.

Workers' Compensation

It is the patient's responsibility to provide our office staff with employer authorization/contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then becomes the patient's responsibility. At your request, we will submit the claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your primary medical insurance carrier's claim is denied, you will be responsible for payment in full.

Missed Appointments

Our office requires 24-hour notice of appointment cancellation.

Returned Checks

Returned checks will be handled by our bank. Please be advised you may receive correspondence from them if they receive a return check.

Minors

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy

It is our office policy that all past due accounts be sent four statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

__________________________________ ________________________

Patient Signature Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request.

but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.

- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fund raising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

InStride Foot & Ankle Specialists Compliance Manager

Phone number: (704) 886-1918

Fax number: (704) 257-2049

Office for Civil Rights
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on 01/01/2017.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: ______________________________

Signature: ______________________________

Date: ____________________

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:

HIPAA AUTHORIZATION FORM

I authorize____ to use and disclose my following protected health information (PHI) listed below for the purpose(s) listed elsewhere on the page.

____

____

Name of entity or person(s) to receive information:

______________________________ ______________________________

______________________________ ______________________________

Describe how the PHI will be used or disclosed, such as date of service, type of service, level of detail to be released, origin of information, etc.

____

____

This PHI is being used or disclosed for the following purposes: *(List specific purposes here.)*

____

____

This authorization shall be in force and effect until *(specify date or event)* ______________________________, at which time this authorization to use and disclose this PHI information expires. *("End of the research study" and "none" is acceptable for authorization for research purposes.)*

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Security Officer at InStride Foot & Ankle Specialists. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use or disclosure requested under this authorization may result in direct or indirect remuneration to the physician from a third party.

______________________________________ ______________________________

Signature of Patient or Personal Representative Date

____

Print Name of Patient or Personal Representative

____

Description of Personal Representative's Authority

DR. JAMES J. MAZUR, D.P.M.

Diplomate, American Board of Podiatric Surgery; Certified in Foot Surgery
Fellow American College of Foot & Ankle Surgeons
A Division of North Carolina Podiatric Physicians and Surgeons Group

PATIENT MEDICAL INFORMATION

NAME: ______________________________

REFERRED BY? ____________________ NAME OF PHYSICIAN: ____________________

WHAT IS YOUR FOOT PROBLEM? ______________________________
( ) LEFT OR ( ) RIGHT FOOT

WAS IT AN ACCIDENT? ( ) YES ( ) NO

IF YES, HOW AND WHEN DID ACCIDENT OCCUR? ______________________________

WHEN DID THE PROBLEM START? ______________________________

HAVE YOU EVER HAD FOOT TREATMENT BEFORE? ( ) YES ( ) NO

IF YES, WHO TREATED YOU? ______________________________

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? ( ) YES ( ) NO

IF YES, WHAT CONDITION ARE YOU BEING TREATED FOR? ______________________________

WHO IS TREATING YOU? ______________________________

HAVE YOU EVER HAD SURGERY? ( ) YES ( ) NO
IF YES, PLEASE STATE TYPE OF SURGERY, YEAR IT WAS PERFORMED AND NAME OF DOCTOR.

____

____

HAVE YOU EVER BEEN TREATED FOR A DISEASE OR ILLNESS? ( ) YES ( ) NO

IF YES, PLEASE STATE TYPE AND DOCTOR WHO TREATED YOU ______________________________

PATIENT MEDICAL STATUS:
PLEASE CHECK APPROPRIATE SPACE(S):

DIABETIC ( ) YES ( ) NO
HIGH BLOOD PRESSURE ( ) YES ( ) NO
HEART DISEASE ( ) YES ( ) NO
ARTHRITIS ( ) YES ( ) NO

POOR CIRCULATION ( ) YES ( ) NO
ASTHMA ( ) YES ( ) NO
ANEMIA ( ) YES ( ) NO
HAY FEVER ( ) YES ( ) NO

SMOKE ( ) YES ( ) NO
HOW MUCH PER DAY? ____________________

ALCOHOL ( ) YES ( ) NO
HOW MUCH PER DAY? ____________________

FAMILY HISTORY: MOTHER FATHER
____________________ ____________________
____________________ ____________________

DRUG REACTION ( ) YES ( ) NO
IF YES, EXPLAIN ____________________

ALLERGIES:
(PLEASE CHECK APPROPRIATE SPACE(S):

PENICILLIN ( ) YES ( ) NO
ASPIRIN ( ) YES ( ) NO
CODEINE ( ) YES ( ) NO

ADHESIVE TAPE ( ) YES ( ) NO
LOCAL ANESTHETIC ( ) YES ( ) NO
OTHER:

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND FOR WHAT CONDITION.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________

I VERIFY, TO THE BEST OF MY KNOWLEDGE THAT, THE ABOVE INFORMATION IS CORRECT.

____________________ ____________________
SIGNATURE DATE

DR. JAMES J. MAZUR, D.P.M.

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Fellow American College of Foot & Ankle Surgeons
A Division of North Carolina Podiatric Physicians and Surgeons Group

PATIENT BILLING INFORMATION

NAME OF PATIENT: ______________________ DATE: __________
(LAST) (FIRST) (MI)

COMPLETE MAILING ADDRESS: ______________________
(IF PO BOX, PLEASE INCLUDE STREET ADDRESS)

____
(CITY) (STATE) (ZIP)

PHONE: __________ BIRTHDATE: __________ AGE: __________ SEX: __________

MARITAL STATUS ( ) S ( ) M ( ) D ( ) W SOCIAL SECURITY # __________

DRIVER'S LICENSE # __________ E-MAIL: __________

____
EMPLOYER'S NAME, ADDRESS AND PHONE NUMBER

____
NAME OF PERSON RESPONSIBLE FOR BILL: (LAST) (FIRST) (MI)

____
RELATIONSHIP TO PATIENT: ADDRESS AND PHONE NUMBER

__________ # __________
SOCIAL SECURITY NUMBER: DRIVER'S LICENSE NUMBER

____
EMPLOYER'S NAME, ADDRESS AND PHONE NUMBER

____
PERSON TO NOTIFY IN CASE OF EMERGENCY: (LAST) (FIRST) (MI)

__________ __________
RELATIONSHIP TO PATIENT REFERRED BY

NAME OF PHYSICIAN: ______________________

INSURANCE ( ) YES ( ) NO

IF YES, PLEASE CHECK HOLDER OF YOUR POLICY: ( ) SELF ( ) SPOUSE ( ) PARENT

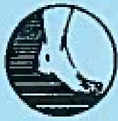
IF VISIT IS FOR AN ACCIDENT, PLEASE GIVE DATE AND PLACE OF ACCIDENT:

____

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and/or ProBill. I am financially responsible for co-payments, deductibles, and non-covered services. I further understand that after my insurance has been filed twice and has not responded, that I will be responsible for full payment of my account and will settle with my insurance company. I have read and understood the Billing Information and I have retained a copy for my reference.

YOUR FULL PAYMENT/CO-PAYMENT IS REQUIRED AT TIME OF SERVICE. THANK YOU!

__________ __________
SIGNATURE DATE



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PATIENT MEDICAL INFORMATION

NAME: ____________________

REFERRED BY? ____________________ NAME OF PHYSICIAN: ____________________

WHAT IS YOUR FOOT PROBLEM? ____________________
( ) LEFT OR ( ) RIGHT FOOT

WAS IT AN ACCIDENT? ( ) YES ( ) NO

IF YES, HOW AND WHEN DID ACCIDENT OCCUR? ____________________

WHEN DID THE PROBLEM START? ____________________

HAVE YOU EVER HAD FOOT TREATMENT BEFORE? ( ) YES ( ) NO

IF YES, WHO TREATED YOU? ____________________

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? ( ) YES ( ) NO

IF YES, WHAT CONDITION ARE YOU BEING TREATED FOR? ____________________

WHO IS TREATING YOU? ____________________

HAVE YOU EVER HAD SURGERY? ( ) YES ( ) NO
IF YES, PLEASE STATE TYPE OF SURGERY, YEAR IT WAS PERFORMED AND NAME OF DOCTOR.

____

____

HAVE YOU EVER BEEN TREATED FOR A DISEASE OR ILLNESS? ( ) YES ( ) NO

IF YES, PLEASE STATE TYPE AND DOCTOR WHO TREATED YOU ____________________

PATIENT MEDICAL STATUS:
PLEASE CHECK APPROPRIATE SPACE(S):

DIABETIC ( ) YES ( ) NO
HIGH BLOOD PRESSURE ( ) YES ( ) NO
HEART DISEASE ( ) YES ( ) NO
ARTHRITIS ( ) YES ( ) NO

SMOKE ( ) YES ( ) NO
HOW MUCH PER DAY? ____________________
FAMILY HISTORY: MOTHER FATHER
____________________ ____________________
____________________ ____________________

POOR CIRCULATION ( ) YES ( ) NO
ASTHMA ( ) YES ( ) NO
ANEMIA ( ) YES ( ) NO
HAY FEVER ( ) YES ( ) NO

ALCOHOL ( ) YES ( ) NO
HOW MUCH PER DAY? ____________________

DRUG REACTION ( ) YES ( ) NO
IF YES, EXPLAIN ____________________

ALLERGIES:
(PLEASE CHECK APPROPRIATE SPACE(S):

PENICILLIN ( ) YES ( ) NO
ASPIRIN ( ) YES ( ) NO
CODEINE ( ) YES ( ) NO

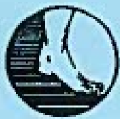
ADHESIVE TAPE ( ) YES ( ) NO
LOCAL ANESTHETIC ( ) YES ( ) NO
OTHER:

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND FOR WHAT CONDITION.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________

I VERIFY, TO THE BEST OF MY KNOWLEDGE THAT, THE ABOVE INFORMATION IS CORRECT.

____________________ ____________________
SIGNATURE DATE



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MEDICARE PATIENT BILLING INFORMATION

NAME OF PATIENT: ______________________________ DATE: ______________
(LAST) (FIRST) (MI)

COMPLETE MAILING ADDRESS: ______________________________
(IF PO BOX, PLEASE INCLUDE STREET ADDRESS)

____
(CITY) (STATE) (ZIP)

PHONE: ____________ BIRTHDATE: ____________ AGE: ____________ SEX: ____________

MARITAL STATUS: ( ) S ( ) M ( ) D ( ) W SOCIAL SECURITY # ____________

DRIVER'S LICENSE # ____________ E-MAIL ____________

______________________________ ____________
EMPLOYER'S NAME, ADDRESS AND PHONE NUMBER

____
NAME OF PERSON RESPONSIBLE FOR BILL: (LAST) (FIRST) (MI)

____
RELATIONSHIP TO PATIENT: ADDRESS AND PHONE NUMBER

____________ # ____________
SOCIAL SECURITY NUMBER: DRIVER'S LICENSE NUMBER

____
EMPLOYER'S NAME, ADDRESS AND PHONE NUMBER

____
PERSON TO NOTIFY IN CASE OF EMERGENCY: (LAST) (FIRST) (MI)

____________ ____________
RELATIONSHIP TO PATIENT REFERRED BY

NAME OF PHYSICIAN: ______________________________

INSURANCE ( ) YES ( ) NO
IF YES, PLEASE CHECK HOLDER OF YOUR POLICY: ( ) SELF ( ) SPOUSE ( ) PARENT

IF VISIT IS FOR AN ACCIDENT, PLEASE GIVE DATE AND PLACE OF ACCIDENT:

____

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. James J. Mazur, D.P.M. for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services." I also understand that I am responsible for any deductible and/or co-payments due to above stated physican/supplier.

____________________ ____________________
SIGNATURE DATE

DR. JAMES J. MAZUR, D.P.M.

Diplomate, American Board of Podiatric Surgery; Certified in Foot Surgery
Fellow American College of Foot & Ankle Surgeons
A Division of North Carolina Podiatric Physicians and Surgeons Group

322 Mocksville Avenue
Salisbury, NC 28144
704-636-7015

MEDICARE AND PODIATRY SERVICES

As a patient with Medicare Part B, we feel it is necessary to make you aware of the services and/or supplies that we furnish that are NOT covered by Medicare Part B.

Treatment and supplies NOT covered by Medicare Part B or Medicaid:

A) Routine Foot Care (see note below)
B) Treatment of Flat Foot
C) Subulaxtions of the foot
D) Splints for treatment of a deformity
E) Secondary Dressings
F) Heel cups, protectors, pads
G) Surgical shoes
H) Orthotics

Please be aware that Medicare NOR Medicaid will cover the cost of Routine Foot Care unless the patient has one of the following diagnosis and is being treated consistantly for that diagnosis at least every six months by their primary care physician:

- Diabetes Mellitus, Peripheral vascular disease, phlebitis/ thrombolitis or peripheral vascular insufficiency.

If Routine Foot Care is given more often than every nine weeks, Medicare will NOT cover even if diagnosis is as above.

Routine Foot Care consists of trimming of corns, calluses and/or nails.

Your signature on this form indicates that you have read and fully understand the above stated information. Also, your signature indicates that you will be responsible for charges incurred if you do not meet the criteria for payment by Medicare and/or Medicaid.

______________________________ patient name

______________________________ date