



KANSAS CITY
PODIATRY
ASSOCIATES

Kansas City Podiatry Associates, P.A.
JEFFREY T. ROITH, D.P.M.

PHONE 913-894-4040
FAX 913-438-4725

PLEASE PRINT AND COMPLETE ALL INFORMATION

PATIENT INFORMATION

Patient Name (Last, First, Initial)			Home Phone		Cell Phone
Address	Social Security #	DOB	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status M S D W
City, State, Zip			Email Address		
Employer	Phone #	Primary Care Physician (PCP)		PCP's Phone #	
Occupation	Business Address		City, State, Zip		

GUARANTOR INFORMATION (Insurance card holder, parent info if patient is a minor, or person responsible for account)

Name		Relationship	Phone #
Address		Social Security #	
City, State, Zip		Occupation	
Employer		Phone #	
Business Address		City, State, Zip	

EMERGENCY CONTACT

Contact's Name		Relationship to Patient
Home Phone ()	Work Phone ()	

INSURANCE INFORMATION (We will also need a copy of your insurance card)

Primary Insurance Company	Name of Insured	Date of Birth	Relationship to Patient
ID #	Group #	SSN of Insured	
Secondary Insurance Company	Name of Insured	Date of Birth	Relationship to Patient
ID #	Group #	SSN of Insured	

HOW DID YOU BECOME AWARE OF OUR SERVICE?
 Referred By: _____ Ins Co Yellowbook Yellow Pages Website Lifetime Fitness

CONSENT FOR TREATMENT AND FINANCIAL ARRANGEMENTS

I, the undersigned certify that I (or my dependent) have coverage with the above insurance company and assign directly to Kansas City Podiatry Associates, P.A. all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient or Responsible Party Signature	If Not Patient - Relationship	Date
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PERMISSION TO SPEAK WITH ANOTHER PARTY REGARDING REMINDER CALLS, MEDICAL RECORDS, AND/OR CHARGES

Patient's Name: _____ DOB: _____

REMINDER CALLS:

<input type="checkbox"/> Home: Leave message <input type="checkbox"/> on answering machine <input type="checkbox"/> with anyone who answers home phone <input type="checkbox"/> only with _____ (Name) <input type="checkbox"/> contact patient only	<input type="checkbox"/> Office: Leave message <input type="checkbox"/> on voice mail at work <input type="checkbox"/> with anyone who answers work phone <input type="checkbox"/> only with _____ (Name) <input type="checkbox"/> contact patient only
<input type="checkbox"/> Other: _____ Phone _____ _____	

MEDICAL RECORDS:

I hereby authorize you to discuss my medical treatment with:

_____	Phone _____
(Person or Party you are permitting to receive information)	
_____	Phone _____
(Person or Party you are permitting to receive information)	
_____	Phone _____
(Person or Party you are permitting to receive information)	

DO NOT RELEASE OR DISCUSS MEDICAL TREATMENT WITH ANYONE OTHER THAN PATIENT AND/ OR RESPONSIBLE PARTY.

ACCOUNT INFORMATION

I hereby give permission for the following individuals to discuss my billing/account information:

_____	Phone _____
(Person or Party you are permitting to receive information)	
_____	Phone _____
(Person or Party you are permitting to receive information)	
_____	Phone _____
(Person or Party you are permitting to receive information)	

DO NOT RELEASE OR DISCUSS BILLING/ACCOUNT INFORMATION WITH ANYONE OTHER THAN PATIENT AND/ OR RESPONSIBLE PARTY.

Signature of Patient or Responsible Party

Date



OFFICE FINANCIAL POLICY

This sheet has been prepared for your benefit. It contains information regarding our billing and insurance procedures. If you have any questions regarding the following policies, please feel free to talk to us about them.

Our office operates on a fee for services basis. All co-pays are due at the time of service. We will file all insurance claims. If we are not contracted with your insurance company, all charges including examination, consultation, x-rays and special tests performed in the office are due and payable in full immediately after you receive your statement. We will accept cash, personal checks, money orders, MasterCard, Visa, and Discover. If other arrangements are necessary please discuss them with our office manager **BEFORE** you see the doctor.

Payment of the doctor's fee is the personal financial obligation of the patient or the person authorizing treatment. This personal obligation is not altered because the patient's charge is covered, in whole or in part, by insurance. **It is your responsibility to know what is and is not covered by your insurance company. It is your responsibility to know whether or not the doctor you are seeing is contracted under your plan.** Full payment is expected within 30 days. Any statement not receiving a payment after 30 days is past due. There will be a \$10 monthly late fee and all balances will be assessed a 1% monthly late charge each month on all balances that are not paid within 30 days. There is a \$30 fee for any check that is returned for insufficient funds. For those patients requiring a referral from their primary physician, as requested by your insurance company... **please note...** it is **YOUR** responsibility to obtain these before coming in for an office visit and/or surgery. Thank you for your cooperation.

I authorize the release of any medical or other information to my insurance company as they request. I agree that a photographic copy of the authorization is a valid as the original.

I hereby authorize payment of medical benefits directly to Kansas City Podiatry Associates, P.A. (Dr. Jeffrey T. Roith) for the services described on the attached claim form.

I understand that regardless of performance by my insurance company I am responsible for payment of my account. In the event that I should default or my account should become seriously delinquent, I agree to pay all reasonable collection costs including but not limited to attorney fees, agency fees, court costs, and the like.

I, _____, **have read the above financial policy and understand my obligation.**
Patient's Name (Printed)

Signature: _____ Date _____

OUR POLICY REGARDING RELEASE OF PROTECTED HEALTH INFORMATION

We are more than happy to forward a copy of your medical records to another physician per your request. You must complete an Authorization For Disclosure of Protected Health Information form (available in our office), and a fee may be charged for handling and reproduction. No original X-rays will be released per HIPAA guidelines. However, a quality digital reproduction will be made available upon request. Please provide a reasonable amount of time for copying.

I have read the above release of information policy and understand its content.

Signature: _____ Date _____