PURVIS-MOYER FOOT & ANKLE CENTER – PMFAC

Dr. Peter Moyer and Dr. Jennifer Purvis / Medical & Surgical Foot & Ankle Specialists

We would like to welcome you to our office. Thank you for choosing us for your podiatric services.

Name_____ _____ _____ _____ Age _____ Birthdate_____ Race_____
First Middle Last Ethnicity. Hispanic / Non-Hispanic

Mailing Address_____City_____State_____Zip_____

Street Address_____City_____State_____Zip_____

County _____ Driver License #/State _____ Sex: M F Marital Status: S M D W

Home Phone _____ Cell Phone _____ E- Mail _____

Social Security Number
Preferred Method of Communication: Phone Portal Email (required in full to be seen) _____

How did you find out about us: Family/Friend Internet Doctor Phone Other _____

Patient's Employer_____ Work # _____

Occupation _____ City / State _____

If disabled, reason for disability_____

Spouse's Name _____ DOB _____ SS # _____

*Nearest Relative Not Living With You _____Relationship _____Phone # _____

The following are permitted to obtain my medical information:_____

Were you referred for consultation? _____ By Whom? _____

Who is your Primary Care Physician? (First & Last Name)_____

Pharmacy/Location _____

INSURANCE INFORMATION

Please provide your insurance card(s) for photo copying. (Without current insurance cards you will be considered a Self-Pay account. No Exceptions.)

PLEASE READ CAREFULLY

I give permission to PMFAC to administer treatment and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my condition. I request that my insurance company pay benefits directly to PMFAC. I agree that I am responsible for any amount not covered by my insurance. I agree that it is my responsibility to obtain any referral necessary from my insurance company or Primary Care Physician as required to process my insurance claims. I give permission to use my cell number as a contact number regarding my account.

In the event that I need hospitalization, surgery and/or durable medical equipment, I agree that it is my responsibility to inform the Doctor of my insurance company requirements regarding precertification, second opinions and other requirements.

I understand that monthly finance charges will be added to overdue accounts I understand that even though Purvis-Moyer Foot & Ankle Center files with my insurance company, if for some reason they do not pay, I accept full responsibility for payment.

AUTHORIZATION TO RELEASE/RECEIVE MEDICAL INFORMATION

I authorize Purvis-Moyer Foot & Ankle Center to release and/or receive medical information to or from my insurance company or any facility that requires information to provide payment or outside care.

ACKNOWLEDGEMENT 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's/Responsible Party's Signature _ X _____

Date _ X _____ **Relationship** _____