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### Victor J. Wright, DPM

Diplomate, American Council of  
Certified Podiatric Physicians and Surgeons  
Fellow, Academy of Ambulatory Foot Surgery



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Phone (863) 534-3668 • Fax (863) 534-8488

4002 Sun City Center Blvd, Ste. A • Sun City Center, FL 33573  
Phone (813) 634-1630

## 1 INSURANCE - Please present your insurance forms, cards and identification to the receptionist

Patient First Name			Middle/Maiden			Last Name			Birth Date / /			Age			Last 4 Digits SSN (Soc.Sec. Number)								
Primary Carrier Name <input type="checkbox"/> Medicare									Secondary Carrier Name <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid														
Claims Address									Claims Address														
City						State			Zip			City						State			Zip		
Phone ( )						Authz. ( )			Phone ( )						Authz. ( )								
Employer or Group Name						Group Number			Employer or Group Name						Group Number								
Insured Name on I.D. Card						Birth Date / /			Insured Name on I.D. Card						Birth Date / /								
Member Policy ID						Patient relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			Member Policy ID						Patient relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other								

## 2 INSURANCE AGREEMENT: DIRECT PAYMENT ASSIGNMENT & INFORMATION RELEASE

❖ I/We hereby name the Doctor(s) and/or Medical Practice given below, hereafter referred to as DOCTOR, as my/our assignee. I/We instruct my/our health care benefits plan provider (i.e.; insurance company, HMO employer, union or government-run health plan), hereafter referred to as the PLAN, to pay the DOCTOR directly for all professional and medical services provided. Payment should be made by means of electronic funds transfer(s) (EFT) or by check(s) made payable to and mailed directly to the DOCTOR:

REMIT TO

**Victor J. Wright, DPM**  
**PO Box 930**  
**Bartow, FL 33830**

*or if my current policy prohibits direct payment to doctors, then I/we hereby instruct and direct the PLAN to make out all checks payable to me/us and mail the payments to me/us in care of the DOCTOR as given directly above.*

### THIS IS A DIRECT ASSIGNMENT OF MY/OUR RIGHTS AND BENEFITS UNDER THIS POLICY.

❖ I/We grant the DOCTOR a limited Power of Attorney to sign my/our name(s) in order to deposit and negotiate any payment received from

the PLAN and apply the funds received toward my/our outstanding balance. These payments will not exceed my/our indebtedness to the above designated DOCTOR. I/We agree to promptly pay any remaining balance due on all professional and medical service charges over and above payment(s) from the PLAN. This Assignment shall remain in effect until cancelled in writing by the DOCTOR.

❖ A photocopy of this agreement, or a electronic facsimile thereof, shall be considered as effective as the original.

❖ I/We understand that personal information about me/us will be needed by the DOCTOR and the PLAN to determine and communicate what services or benefits are covered by the PLAN, and to submit or process a claim for payment on services rendered and for the DOCTOR to collect all fees owed for those services. Therefore, for the purpose of obtaining payment for services rendered, I/we give to the DOCTOR, the PLAN, the Centers for Medicare & Medicaid Services (CMS), their agents, and/or any other holder of information about me/us, authorization to release and/or exchange medical, billing and collection information.

Signature of Policy holder

Date: / /

X

Signature of Patient (if other than Policyholder)

Date: / /

X

## 3 ACCOUNT TERMS AND PAYMENTS FOR NON-INSURANCE-COVERED ITEMS AND SERVICES

Today, I will pay my bill by:  Cash  Check No. \_\_\_\_\_  
 Visa  MasterCard  Discover

In the Future, I can pay my bill by:  Cash  Check  
 Visa  MasterCard  Discover

Referencing Sec. 7 on back: On accounts w/ balances due over 60 days:  
 Your MONTHLY FINANCE CHARGE is 1.00% (ANNUAL PERCENTAGE RATE 12.00%). Your MONTHLY COST OF REBILLING / ACCOUNT MAINTENANCE CHARGE is \$8.00

## 4 REFERRAL SOURCE - Please tell us how you chose us to provide your medical care?

Who deserves a thank you for referring you to us?

A  Friend  Doctor  Nurse  or Other?

At Hospital/Office of: \_\_\_\_\_

City: \_\_\_\_\_

Otherwise, how did you learn about us?

Insurance Company Provider List

Web Site: \_\_\_\_\_

Claims Adjuster (Insurance Co.: \_\_\_\_\_ Claim # \_\_\_\_\_)

Saw name when passing by

Yellow Pages

Brochure / Literature

Newspaper/Magazine

Medical Lecture

Other - \_\_\_\_\_

Referral Service

Mail

New Patient  UPDATE from / /

INITIAL INSURANCE

ANNUAL INSURANCE UPDATE

ONLY CHANGES NOTED

PATIENT INSURANCE

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First Name		Middle Name		Last Name		Employer or School	
Home Address				Work / School Address			
City		State		Zip Code		City	
Home Phone ( ) - ( ) - ( )		Birth Date / /		<input type="checkbox"/> M <input type="checkbox"/> F		Work Phone ( ) - ( ) - ( )	
Street Location Number		Apartment		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Employed by employer for: <input type="checkbox"/> weeks <input type="checkbox"/> months <input type="checkbox"/> years	
E-mail Address to use with patient:		Occupation <input type="checkbox"/> Student <input type="checkbox"/> Retired		Emergency Care / First Name		Last Name	
				City		Phone ( ) - ( ) - ( )	
						Date Last Seen / /	

SPCUSE/FIRST PARENT INFORMATION				SECOND PARENT/GUARDIAN INFORMATION			
First Name		Middle Name		Last Name		First Name	
Middle Name		Last Name		First Name		Middle Name	
Last Name		First Name		Middle Name		Last Name	
Name Address				Name Address			
<input type="checkbox"/> BASED AREA (SEE INSTRUCTIONS)				<input type="checkbox"/> BASED AREA (SEE INSTRUCTIONS)			
City				City			
State		Zip Code		State		Zip Code	
Home Phone ( ) - ( ) - ( )		Birth Date / /		<input type="checkbox"/> M <input type="checkbox"/> F		Birth Date / /	
Work Phone ( ) - ( ) - ( )		Admitted to Patient <input type="checkbox"/> Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		Work Phone ( ) - ( ) - ( )		Enrolled in Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other	
Street Location Number		Apartment		Street Location Number		Apartment	
Last 4 Digits of E-mail contact address		E-mail contact address		Last 4 Digits of E-mail contact address		E-mail contact address	
Employer School		Employed by employer for: <input type="checkbox"/> weeks <input type="checkbox"/> months <input type="checkbox"/> years		Employer School		Employed by employer for: <input type="checkbox"/> weeks <input type="checkbox"/> months <input type="checkbox"/> years	
Work/School Address		Work/School Address		Work/School Address		Work/School Address	
City		State		Zip Code		City	
Occupation <input type="checkbox"/> Student <input type="checkbox"/> Retired		Occupation <input type="checkbox"/> Student <input type="checkbox"/> Retired		Occupation <input type="checkbox"/> Student <input type="checkbox"/> Retired		Occupation <input type="checkbox"/> Student <input type="checkbox"/> Retired	

### 7 FINANCIAL AGREEMENT, AUTHORIZATION FOR TREATMENT & INFORMATION RELEASE

The Responsible Parties whose signatures appear below agree as follows:

- ◆ The Doctor(s), Associate Doctor(s), and staff of the Medical Practice, named on the reverse side of this form and hereinafter referred to as DOCTOR, are authorized to medically treat the patient named on this form.

- ◆ DOCTOR is authorized to collect, use and exchange protected health information (PHI) consisting of the patient's past, present, future medical information and other personal information to treat the patient, communicate with the patient's other health care providers, seek payment, carry out necessary business functions and mandated government reporting requirements. These situations and others, as well as your rights regarding this information are explained in our separate HIPAA Notice of Privacy Practices (NPP) provided to you.

- ◆ The Responsible Parties agree to pay for all fees and charges for supplies, services and treatment that are incurred by the patient per the terms of this agreement and authorize DOCTOR or agents thereof to make credit investigations, including employment verifications. All charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date. The Responsible Parties remain, jointly and severally, financially responsible for the patient until the DOCTOR receives their notification in writing to the contrary if the patient is currently a minor, their guarantee is continuing even after the patient reaches the age of majority.

- ◆ Not all services and/or fees are covered or paid for by the Responsible Parties' health PLAN. Therefore, the Responsible Parties agree to pay for all deductibles, co-payments, non-covered services, and any portion of covered services not paid in full by the PLAN and understand that such payments are due at the time of service or immediately upon presentation of the bill.

- ◆ All proceeds from the PLAN are assigned to DOCTOR where applicable. Payments to DOCTOR may not be withheld, delayed or excused for any reason, including the outcome of medical treatment, liens, lawsuits, any coverage determination by the PLAN or their processing of claims, the financial solvency of

the PLAN and/or their contracted intermediaries & medical groups. Responsible Parties are strongly advised to monitor and communicate with the PLAN to ensure that DOCTOR's claims are paid promptly, since they, as Responsible Parties, are ultimately financially responsible for all amounts owed to DOCTOR.

- ◆ If any account balance is not paid in full within 60 days, the entire account balance will be subject to a MONTHLY FINANCE CHARGE and a MONTHLY COST OF REBILLING / ACCOUNT MAINTENANCE CHARGE at the rates listed previously in Section 3 on the reverse side of this form. These rates and charges are subject to change upon written notice 30 days in advance of changes.

- ◆ If any account balance should remain unpaid for 60 days and DOCTOR refers the account to a collection agency or attorney for collection, Responsible Parties agree to pay the costs of collection and that such fees and costs may be added to the account balance. In a legal action between the parties to this agreement to collect an unpaid balance due for medical services rendered, the prevailing party shall be entitled to recover reasonable attorney's fees and costs.

- ◆ The Responsible Parties acknowledge receipt of DOCTOR's Office Policy that includes the terms of this Financial Agreement, Authorization for Treatment & Information Release. This form together with DOCTOR's Office Policy and NPP contain the entire and only agreements between the parties. There are no other agreements, promises, representations or warranties, expressed or implied. The provisions of these agreements shall not be changed or modified except by an instrument in writing signed by the parties hereto.

#### Agreed to and accepted by the Responsible Parties:

Signed by First Responsible Party (Patient or, if patient is under 18 years old, Parent, or Guardian; Spouse or other Guardian) on this DATE:

X

Signed by Second Responsible Party (if patient is under 18 years old, Second Parent, or Guardian; Spouse or other Guardian) on this DATE:

X

Pages 1 & 2 reviewed by:

Confidential Office Medical Record  
DOCUFORMS® FOD-1010 - Page 2 of 2

New Patient  
 BSMTE form

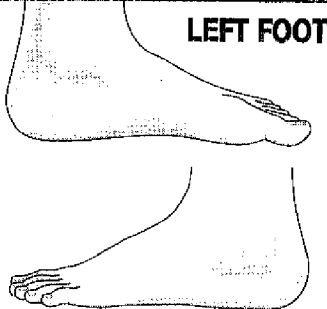
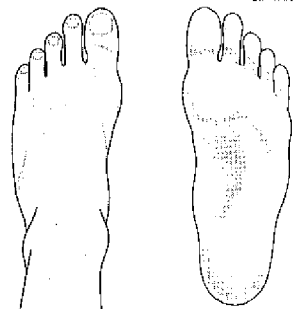
3

PATIENT'S CURRENT CHIEF COMPLAINTS

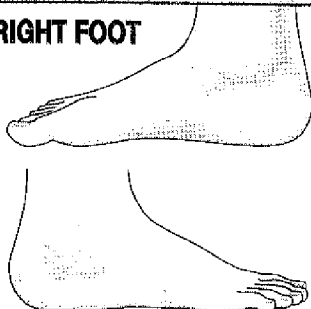
CC/HPI

Patient CC# (s)

Describe 1 or 2 main problems in greater detail below & mark on the diagrams below the areas where you have each problem using numbers 1 & 2 to identify them.



LEFT FOOT



RIGHT FOOT

1 Please mark the location of your first problem or pain on the diagrams above with a number 1. Describe your problem below and its cause if you know. Please describe associated pain to the right. My first problem is ... On Left foot On Right foot On Both feet. It causes me difficulty: walking, wearing shoes, and/or it ...

Form for problem 1 with checkboxes for pain types (Shooting, Throbbing, Sharp, Burning, Itching, Aching, Tenderness, Dull, Tingling, Numbness) and a section for 'How long ago did the problem (pain) start?' and 'The pain from my problem occurs:'.

Is problem work related? Y N Date of injury: / / Date of report to employer: / /

2 Please mark the location of your second problem or pain on the diagrams above with a number 2. Describe your problem below and its cause if you know. Please describe associated pain to the right. My second problem is ... On Left foot On Right foot On Both feet. It causes me difficulty: walking, wearing shoes, and/or it ...

Form for problem 2 with checkboxes for pain types and a section for 'How long ago did the problem (pain) start?' and 'The pain from my problem occurs:'.

Is problem work related? Y N Date of injury: / / Date of report to employer: / /

PAIN: Please indicate the severity of your pain or discomfort: 0 None ... 1 Light ... 2 Moderate ... 3 Strong ... 4 Severe

Pain severity and description form for problem 1.

PAIN: Please indicate the severity of your pain or discomfort: 0 None ... 1 Light ... 2 Moderate ... 3 Strong ... 4 Severe

Pain severity and description form for problem 2.

4

PATIENT'S DOCTORS - PLEASE TELL US WHOM TO THANK AND WITH WHOM TO COORDINATE YOUR CARE

Table for listing doctors with columns for My: Family/Primary, Specialist, Other Podiatrist, Physician's Name, Phone Number, City, Date Last Seen, Referred me: I was sent or came in especially for: (2nd Opinion, Surgcl Eval, Consult).

5

FOR DOCTOR'S USE - OBSERVATIONS & COMMENTS

Form for doctor's observations with checkboxes for 'Patient was assisted in completion of this record by or was unable to complete without the help of:', 'Translation was done by', 'Additional Information† obtained from', 'Lab Reports† and/or Previous Medical Records† were reviewed.', 'X-rays† brought by patient from', and 'Elaborations:'.

I have reviewed the information provided above My annotations to patient's entries are marked in: (INK COLOR) Doctor's Signature X Date / / MR See Additional Documentation

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PATIENT HISTORY

PATIENT NAME Last, First, Middle

Medical Record # or Last 4 Digits of SSN

Sex Age DOB

