George L. Yarnell, DPM
23 N. Lansdowne Ave., Suite #3, Lansdowne, PA 19050
(610) 626-3338

_____ _____ _____
First name *Middle Initial* *Last name*

_____
Social Security Number

_____
Email

_____
Mailing Address

City _____ **State** _____ **Zip** _____

Phone _____ **Age** _____ **Date of Birth** _____ **Sex** _____

Marital Status _____ **Height** _____ **Weight** _____ **Shoe Size (Length and Width)** _____

Race _____ **Ethnicity** _____ **This information is requested due to Healthcare Reform laws dictated by Congress.*

Preferred language _____ **Other language** _____

Are you pregnant _____ **Are you nursing** _____

Have you completed an Advance Directive (living will)? _____

Primary Care Physician _____

Primary Care Physician Address _____

Physician Phone Number _____ **Date Last Seen** _____

Pharmacy _____ **Pharmacy Phone** _____

Whom may we thank for referring you? _____

Other _____

Primary Reason for Visit

Duration of Condition

What helps / makes it worse?

Is it limiting your desire activity level?

Secondary concerns (if there are any)

Please list any drug allergies

List Medications You Take

Medical History

Other history

If you have cancer, please list type and treatment

What surgeries have you had?

Trauma / Accidents

Social History

Do you drink alcohol _____ **If you answered yes above, do you abuse alcohol?** _____ **How often** _____

Do you participate in a regular physical fitness program?

_____

Please Specify _____

Do you smoke, vape or use chewing tobacco _____

Specify _____ **How many per day** _____

Do you have/have had a substance abuse problem _____ **If you answered "past" above, when did you stop?** _____ **Specify** _____

Family History

Diabetes _____ **Stroke** _____

Cancer _____ **Arthritis** _____

Heart Attack _____ **HTN** _____

Other _____

Insurance Information

Subscribers name _____ **Subscribers D.O.B.** _____

Patient's Relation to the Subscriber _____

If a Patient Has a Different Address Than Subscriber Please State the Patients Address _____

HMO _____

Primary Insurance _____

Policy Number _____ **Policy Holder Date of Birth** _____ **Policy Holder Name** _____

Secondary Insurance _____

Secondary Policy Number _____

Occupation _____

Employer _____

Employer Address _____

City *test* _____ **State** _____ **Zip** _____

Employer Phone Number _____

Emergency Contact

First Name _____ **Last Name** _____

Relationship to Patient _____ **Phone** _____

Responsible Party (if minor patient)

First Name _____ **Last Name** _____

Relationship to Patient _____ **Date of Birth** _____

For any insurance plan that requires authorization from a primary care physician (e.g. HMO, PPO, etc.) it is your responsibility (as patient or guardian) to be sure that this office receives all necessary referrals or authorizations PRIOR to treatment. Professional services are rendered and billed directly to your insurance carrier; however you, the patient/guardian, are directly responsible for services rendered by the doctor. A health insurance policy is a contract between you (the patient or subscriber) and your insurance carrier. You MUST notify this Office of any changes to your insurance policy including policy termination, changes in co-payments or a new insurance policy. If for any reason the insurance carrier denies charges, payments for any services rendered will become the responsibility of the patient/guardian.

I Agree (*)

All office visit charges and co-pays are due at the time services are rendered. It is the patient themselves whom are responsible for their financial aspects of services rendered. There will be a charge for returned checks. I agree to pay for all deductibles, co-pays, non-covered services and any portion of covered services not paid in full by my insurance plan and understand that such payments are due at the time of service or immediately upon presentation of the bill. I hereby authorize payment of medical benefits to George L. Yarnell, DPM , who will accept the assignment of medical benefits. I Instruct my health care benefits plan administrator, i.e. PLAN to pay George L Yarnell, D.P.M directly for all professional and medical services provided by George L Yarnell, D.P.M. through the means of electronic funds transfer(s) (EFT) or by check(s) made payable to and mailed to George L Yarnell, D.P.M.. I AUTHORIZE THE RELEASE IF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS.

I Agree (*)

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. • I also give permission for photographs of my feet to be taken that are to be kept as part of my medical record only. They will not be published as part of medical research or disbursed in any way without my permission.

I Agree (*)

PAYMENT RESPONSIBILITIES

We are pleased to welcome you to our office. New Patients are always appreciated. Our practice has grown as a result of its excellent relationship with our referring doctors and patients. As our patient, please feel free, at any time, to express any concerns or to ask any questions that you may have for the doctor or our staff. In order to assist you in making payment(s) for your podiatric treatment, the following options are listed. Please read them carefully and feel free to discuss them with us.

If you DO NOT have insurance: Payment is due, in full, at the time treatment is provided. Payment arrangements can be made.

*For your convenience, we accept all major credit/debit cards and cash.

If you have Insurance: The percentage of coverage by your insurance company may be based on your insurance company's own reduced fee schedule for medical services and may be less than actual charges resulting in lower coverage for you. The office of George L. Yarnell, D.P.M. has no control over this situation. *Lower payment is a direct result of the plan selected by you or your employer.* **Please be advised that we cannot waive co-payment. We are required by law to collect co-payment and deductibles.**

Commercial Insurance: We will submit your claim to your insurance carrier for you. You are responsible for any deductible or co-payment not covered by your insurance. Once our office has received payment from the insurance company, you will be billed, with 30 day terms, for any amount still owed. You may choose to keep a credit card on file for those balances left to you by your insurance company.

Medicare: This office accepts Medicare assignment. Medicare patients are fully responsible, however, for the initial yearly deductible and the 20% co-insurance. Federal law requires that physicians collect this amount. If you have a secondary insurance to cover the 20%, we will submit the balance to that insurance for payment and you will only be responsible for the yearly deductible.

_____ _____

Signature *Date*