STRIDE
FOOT & ANKLE CENTER, LLC
Dr. Claude Mayembe, DPM

MOBILE PODIATRY REGISTRATION FORM

All Fields are REQUIRED. Leave no blanks – use "N/A" or "None," as applicable.

SECTION 1: FACILITY INFORMATION

Name: _____ Phone: _____ Fax: _____
Address:_____ City: _____ State: _____ Zip: _____
Reason (s) for referral_____
Facility Contact Name/title: _____

SECTION 2: PATIENT INFORMATION

□ Mr □ Ms □ Mrs First: _____ MI: _____ Last:_____
DOB: _____ Height: _____ Weight: _____ Shoe size: _____ **Diabetic: Yes____ No_____**
Primary Phone: _____ Type: □ Cell □ Home Email: _____
Responsible Party (if other than patient)
Name: _____ Address: _____
Phone Number: _____ Relationship to Patient: _____

SECTION 3: INSURANCE INFORMATION (Attach copy of each insurance card)

Primary Insurance: _____ **Policy Number:** _____
Secondary Insurance: _____ **Policy Number:** _____

SECTION 4: PATIENT PAST MEDICAL HISTORY

_____
_____
_____

SECTION 5: PATIENT MEDICATION (*attach medication list if more space needed*)

_____
_____
Allergies: _____Smoking: □**Y**es □ **N**o □ **Ne**ver If Yes, How long _____

SECTION 6: PHYSICIAN INFORMATION

Primary Physician: _____ Last Seen: ____/____/_____ Phone: _____
Previous Podiatrist: _____ Last seen: ____/____/_____ Phone: _____

SECTION 7: PHARMACY

Name: _____ **Phone:** _____
Address: _____ **City:** _____ **Zip:** _____

SECTION 8: CONSENT FOR PODIATRIC TREATMENT

Patient's Signature: _____ **Date:** _____
Responsible Party/Guarantor's Signature (if applicable): _____ **Date:** _____

FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW:

Your understanding of our financial policy is an essential part of your treatment. By signing this agreement you acknowledge herewith, that you have **voluntarily** entered into a financial agreement with STRIDE FOOT & ANKLE CENTER, LLC, a professional Limited Liability Company, for Podiatric Medical and Surgical services.

Insurance: Our office participates with Medicare, Medicaid and other commercial insurance companies. I acknowledge that Stride Foot & Ankle Center, LLC will file my Insurance as a Courtesy. Any Co-pay, Deductible or Non-Covered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit.
Co-Pays: All co-payments are due at the time of service without exception and are your responsibility. If you do not have your co-payment you may be asked to reschedule your appointment for a later date.
Uninsured patients: if you are uninsured, a free estimate of expected charges based on anticipated services will be provided to you. We require a deposit of **$200** prior to receiving services. This amount can be paid in cash, debit/credit card. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed $200, payment is required at that time.
Referral: You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.
I have read, understood and accept the terms stated above.

_____ _____
Printed patient name Patient Signature/Responsible Party

Fax Completed Form to: ***Goodness Mayembe,*** *Practice Manager.* ***FAX* # 678-926-3550** or call **678-288-9205** for further assistance