Robert G. Lawson, DPM
15644 Pomerado Road, Suite 300, Poway, CA 92064
Tel: (858) 485-1494 Fax: (858) 613-9274

Diplomate, American Board of Podiatric Surgery
215 South Hickory Street, Suite 118, Escondido, CA 92025
Tel: (760) 480-1189

REGISTRATION FORM

[1] PATIENT INFORMATION

Patient's Last name:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)
First: **Middle:**			Single / Married / Divorced Separated / Widowed
Is this your legal name? ❑ Yes ❑ No	Birth date: / /		Age:
If not, what is your legal name?	Former Name:		Sex: ❑ M ❑ F
Street address:	Home phone no.: ( )		
	Social Security no.:		
City: State:	ZIP Code:		
Occupation:	Cell Phone: ( )		
Employer:	Work phone no.: ( )		
Employer Address:			
Chose clinic because/Referred to clinic by (please check one box):	❑ Dr. ❑ Insurance Plan	❑ Hospital	
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages		❑ Other	
Other family members seen here:			

[2] INSURANCE/RESPONSIBLE PARTY INFORMATION
(If same as above, please do not complete Section [2]

Person responsible for bill:	Birth date: / /		
Address (if different):	Social Security no.:		
	Home phone no.: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No	Work phone no.: ( )		
Employer:	Occupation:		
Employer address:			
Please indicate primary insurance ❑ Medicare ❑ HMO ❑ PPO	❑ Medicare/Medical	❑ Other	
Insurance company name: Group no.:	Policy no.:		
Subscriber's name: Birth date: / /	Co-payment:$		
Patient's relationship to subscriber: ❑ Self ❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):			
Group no.: Policy no.:			

[3] IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Home phone no.: ( )
Relationship to patient:	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Robert G. Lawson, DPM or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

[4] REFERRAL SOURCE

Who deserves a thank you for referring you to us?
❑ Friend ❑ Doctor ❑ Nurse ❑ Other

At Hospital/Office of:_____

City: _____

How did you learn about us?
❑ Insurance Company Provider List
❑ Claims Adjuster
❑ Referral Service
❑ Website
❑ Yellow Pages
❑ Saw Name when passing by
❑ Mail
❑ Newspaper/Magazine

[5] ACCOUNT TERMS AND PAYMENTS FOR NON-INSURANCE COVERED ITEMS AND SERVICES

Today, I will pay my bill by: ❑ Cash ❑ Check No. _____

❑ VISA ❑ MasterCard ❑ Discover ❑ American Express

On accounts with 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 $10.00.

[6] INSURANCE AGREEMENT: DIRECT PAYMENT ASSIGNMENT & INFORMATION RELEASE

I/We hereby name the Doctor 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: **Robert G. Lawson, DPM**
15644 Pomerado Road, Suite 300
Poway, CA 92064
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 names(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 electronic facsimile thereof shall be considered as effective as the original.
- 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 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 and/or any other holder of information about me/us, authorization to release and/or exchange medical, billing and collection information.

X_____ Date _____
Signature of Policy holder

X_____ Date _____
Signature of Patient (if other than Policyholder)

[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 hereafter referred to as DOCTOR, are authorized to medically treat the patient named on this form.
- DOCTOR is authorized to collect, use and exchange individually identifiable health information (IIHI) 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 and carry out necessary business functions. A patient may request to see IIHI pertaining to themselves, request copies, ask for corrections or amendments to the IIHI and request in writing request restrictions on its' future use. DOCTOR is not obliged to honor all requests.
- The Responsible Parities 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 patients 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 Parities 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 understands 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 insolvency of The PLAN and/or their contracted intermediaries & medical groups.

Responsible Parities are strongly advised to monitor and communicate with the PLAN to ensure that DOCTOR's claims are paid promptly, since they, as Responsible Parities, 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 2 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 Parities agree to pay the costs of collection and that such less and fees and costs may be added to the account balance. In a legal action between the parties to this agreement to collection an unpaid balance due for medical services rendered, the prevailing party shall be entitled to recover reasonable attorney's fees and costs.
- The Responsible Parities 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 contains the entire and only agreement 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 for an Instrument in writing signed by the parties hereto.

Agreed to and accepted by the Responsible Parties:

X_____ Date _____

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

X_____ Date _____

Signed by Second Responsible Party (Patient or, if patient is under 18 years old, Parent, or Guardian; Spouse or other Guarantor)

MEDICAL HISTORY

ALLERGIES OR SENSITIVITIES:

( ) No history of known allergies ( ) Penicillin ( ) Tape ( ) Metal ( ) Iodine ( ) Foods

Other Antibiotic_____

Local Anesthetic_____

Medicines_____

MEDICATIONS:

_____ Rx'ed by _____

_____ Rx'ed by _____

_____ Rx'ed by _____

_____ Rx'ed by _____

PAST MEDICAL HISTORY:

HOSPITALIZATION AND SURGERIES

1) 5)

2) 6)

3) 7)

4) 8)

SEVERE ILLNESS

Diabetes, Bleeding Problems, STDs, Aids or HIV positive, Hepatitis B or C, Bronchitis, Asthma, TB, Heart disease, High or Low Blood Pressure, Liver disease, Arthritis, Cancer, Seizure disorder, Skin problems or Stroke, Polio, Vision Problems

_____

_____

_____

_____

_____

PREVIOUS TRAUMA

(Broken bones, dislocations, sprains & strains)

_____

_____

_____

_____

_____

CHILDHOOD ILLNESS

Measles, Mumps, Chickenpox, Whooping cough, Scarlet fever, Rheumatic fever, Diptheria

_____

_____

_____

_____

SOCIAL HISTORY

Tobacco Use _____ Pks/Day Alcohol _____

FAMILY HISTORY OF:
(Please circle)

Cancer, Diabetes, TB, Heart trouble, High Blood Pressure, Stroke, Bleeding tendency, Arthritis, Gout, Alcoholism, Epilepsy, Asthma, Emphysema, Foot problems