Tanya R. Sellers-Hannibal, DPM, PC

Podiatric Medicine & Surgery

The Physicians' Pavilion @ Owings Mills
10085 Red Run Blvd. - Suite 305
Owings Mills, MD 21117
Tel 410.581.8331 · Fax 410.581.8332

Welcome to our office!
We request that ALL NEW PATIENTS complete this form in its entirety. Thank you!

Date __________________ Chart #: ___________

Patient's Name ________________________________ Gender: M ___ F ___
Date of Birth (M.D.Y) ______.______._______ Social Security # ______.______.______
Address (No PO Boxes Please) ______________________________ Apt _________
City ______________________ State ____________ Zip Code _________
(If patient a minor, please list parent/authorized individual's contact numbers)
Home Phone _____ . ______ . ________
Work Phone _____ . ______ . ________ extension _______
Other _____. ______ . __________ (cellular: yes/no)
Email ____________________@__________.________

Primary Language Spoken _____________________
Race: African American/Black ____ American Indian/Alaska Native ____ Asian ____
Caucasian ____ Native Hawaiian/Other Pacific Islander ____ Other ____
Ethnicity: Hispanic/Latino _____ Not Hispanic/Latino ____ Not Specified ____

Employment Status: Full Time ____ Part Time ____ Not Employed ____
Employer _________________________ Occupation ______________________
Student Status: Not a Student __ Full Time __ Part Time __

Marital Status: Single __ Married __ Divorced __ Widowed __ Legally Separated __
Spouse's Name ________________________
Spouse's Contact Number _____ . _____._______ (cellular/work/home)

Emergency Contact _________________________ Relationship _______________
Emergency Contact Number _____ . ______.________ (home/work/cellular)

Primary Insurance Company __________________ Employer __________________
Policy Holder Name _____________________ Relationship: Self/Spouse/Parent
Policy Holder Date of Birth (M.D.Y) ____.____._____ (if other than self)

Primary Care Physician _______________________ Telephone _____._____._______
Former Podiatrist __________________________

Preferred Pharmacy___________________ Telephone _____.______.________
Location (Town or Street Address) ______________________
Preferred Contact via: Home Phone __ Cellular Phone __ Work Phone __
Leave Message With: Patient Only __ Spouse __ Whomever Answers __ No One __

Referred By: Doctor____ Family/Friend ____ Insurance ____ Internet/Google _____
Name (if doctor or family/friend): ____

What problems bring you to our office:

____

____

____

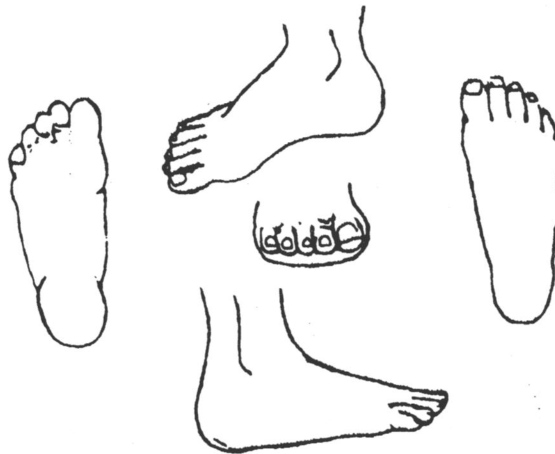
____

____

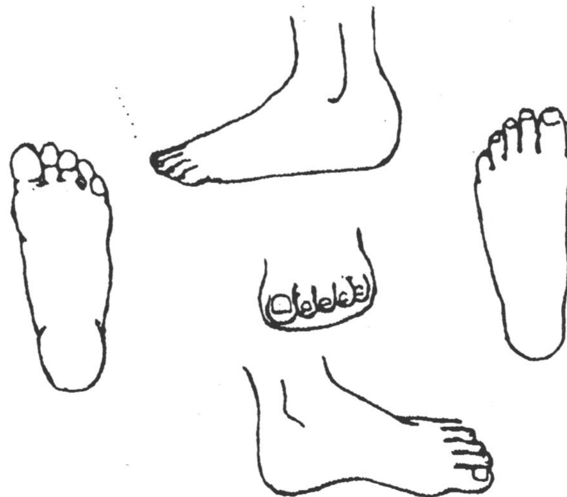
____

On the diagram below, please mark the place(s) where you are experiencing the problems listed above.

RIGHT FOOT



LEFT FOOT



It is our pleasure to soothe your sole step by step!

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Welcome to our office!
We request that *ALL NEW PATIENTS* complete this form.
Thank you!

Please read *ALL* statements below as they apply to *ALL PATIENTS*!

PATIENT AUTHORIZATION

I,______________________________, hereby authorize Tanya R. Sellers-Hannibal, DPM, PC, to apply for benefits on my behalf for covered services rendered. I request payment from Blue Cross Blue Shield of Maryland, Medicare, Medicaid, and/or __________________ Insurance Company(ies), be made directly to Tanya R. Sellers-Hannibal, DPM, PC, (or in case of Medicare Part B benefits, to myself or the party who accepts assignment).

I certify that the information I (or my dependent) have reported concerning my insurance coverage is correct and further authorize the release of any necessary information, (including medical and/or surgical information) for this or any related claim, to the above named billing agent (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Finance Administration), the insurance company named above, or myself. Therefore, I hereby authorize Dr. Tanya R. Sellers-Hannibal to release and/or obtain any and all necessary information to secure the payment of benefits. I permit a copy of this patient authorization to be used in place of the original for all insurance submissions. This authorization may be revoked, in writing, by either myself or the above named carrier at any time.

I request that payment of authorized Medigap benefits be made either to myself or on my behalf to the above named podiatric physician for any services furnished me by that provider. I authorize any holder of medical information about me to release to Dr. Tanya R. Sellers-Hannibal any and all information needed to determine these benefits payable for this or any related service.

___________________________________ ______________
Authorized Individual's Signature **Date**

____
Relationship to Patient (if other than self)

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It is our office policy that all charges (deductibles, co-payments, etc.) for office visits, procedures, and surgery are due at the time services are rendered. We will bill insurance companies for office visits, procedures, and surgery in cases where the office has an established relationship with the carrier (such as Medicare, Blue Cross Blue Shield, Medicaid, some HMOs, and certain other carriers) as a courtesy for our patients. If the office does not have an established relationship with your carrier, charges for office visits, procedures, and surgery are due at the time of service except when prior arrangements have been made. We will gladly help you in filing for reimbursement with your insurance carrier.

Please understand that insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. As such, *you, the patient, are fully financially responsible* for all medical and/or surgery charges whether or not you have medical coverage. If there is a difference between the amount billed and the amount paid by the insurance carrier, the remaining balance is the responsibility of you, the patient

In cases where fees for services must be billed to you, the balance is due within the 30 days of the billing date. Any payments not received within the first 30 days will be subjected to a monthly interest rate charge of 1.5%. Payments not received within 45 days will be promptly forwarded to the collection agency.

- Therefore, I agree to pay any costs incurred in collecting any unpaid balance due to Dr. Tanya R. Sellers-Hannibal including collection agency fees, court costs, and/or attorney fees.
- I understand that payment for office visits is due at the time of services are rendered unless prior arrangements have been made with the office manager and/or Dr. Sellers-Hannibal.
- Additionally, I understand that I will be billed $35.00 for any returned check presented to the office for payment. And further, the office reserves the right not to accept future checks if any checks have been returned previously.

My method of payment today will be by: Cash____ Check____ Mastercard____ Visa____

____ ______________

Authorized Individual's Signature **Date**

____

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HIPAA PATIENT CONSENT FORM

Patient: ______________________________ Acct #: ______________

I understand that, under the Health Insurance Portability & Accountability Act (HIPAA) of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by this office's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that the practice has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time (as listed above) to obtain a current copy of the Notice of Privacy Practices.

I understand, that I may request in writing, that the practice restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that the practice is not required to agree to my requested restrictions, but if the practice does agree then the practice is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the practice has taken action relying on the previous consent.

______________________________________ ______________

Authorized Individual's Signature **Date**

____

Relationship to Patient (if other than self)

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Again, welcome to our office!
We kindly request that legal guarantor of all minor patients complete this form in its entirety.
Thank you!

Date ______________________

Patient's Name ________________________________

Legal Guarantor Name ____

(Information needed below is for the legal guarantor.)

Date of Birth (M.D.Y) _______ . _______ . _________

Social Security # ________ . ___________ . ___________

Address (No PO Boxes Please) ______________________________ Apt __________

City __________________________ State ______________ Zip Code ____________

Home Phone __________. ___________. ___________

Work Phone __________. ___________. ___________

Mobile Phone __________. ___________. ___________

Preferred Contact via: Home Phone _____ Work Phone _____ Mobile Phone _____

Leave Message With:
Legal Guardian Only _____ Spouse (If applicable) _____
Whomever Answers _____ No One____

A copy of your driver's license is also required.