DR. GREGORIO CABAN D.P.M.

BOARD CERTIFIED IN FOOT, ANKLE
&
RECONSTRUCTIVE REAR FOOT SURGERY

Financial Policy

This is an agreement between Dr. Caban, as creditor, and Patient/Debtor named on this form.

By executing this agreement, you are agreeing to pay for all services that are received. Payment is expected at the time services are rendered. We accept cash, Visa and Master Card. We collect copay, coinsurance and deductible at the time services are rendered.

Insurance: Insurance is a contract between you and your insurance company. We will file insurance claims only for plans with whom we have a contract with. We participate in some managed care plans. In order to file your claims, we require a legible copy of the front & back of the insurance card, photo ID, social security number and verification of benefits by your insurance company prior to visits. It is the responsibility of the insured/patient to supply current and accurate information for claim submissions. All copay, coinsurance and deductibles are due at the time services are rendered.

If you are covered by a plan that we are not participating providers for, payment is expected when services are rendered. We will provide you with itemized receipt for you to file insurance. Your insurance company will be responsible for reimbursing you for any coverage you may have.

Collection fee: A fee totaling 30% of the balance due will be added to your account if we have to send your account to a collection agency. You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account to any credit reporting agency such as a credit bureau.

Waiver of confidentiality: You understand if this account is turned over to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Return checks: There is currently a fee of $35.00 for any checks returned by the bank. Payment made on a returned check must be made in cash or by a money order.

Copying of records: You will need to request in writing, and pay a reasonable copying fee. ($ 1/page for the first 25 pages and 25 cents for every page thereafter) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Consent of photograph: I authorize Dr. Caban and its affiliates to take pictures of my (or my child's) medical or surgical procedure(s) and condition(s) and to the use of pictures for treatment, scientific, educational or research purposes.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force affect.

My signature below certifies that I have read (or the form has been read to me) and I understand the contents of this form.

Patient's name: _____ **Date:** _____

Responsible party (if not the patient): _____

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Acknowledgement of Privacy Practices

I hereby acknowledge that I have received a copy of Dr. Gregorio Caban Notice of Privacy practices as required by the federal law.

Patient Signature: _____ **Date:** _____

Reason Patient/ Personal representative failed to sign:

_____
_____
_____

Staff Signature: _____ **Date:** _____

Patient consent for use and disclosure of Protected Health Information

Patient Name: _____ **Date of Consent:** _____

I authorize the office of Dr. Gregorio Caban to disclose health protected information to the following:
Name and relationship of person(s) authorized to receive information:

_____
_____
_____

Please circle one:

I DO [ ]

I DO NOT [ ]

Authorize the office of Dr. Gregorio Caban to leave telephone messages regarding my protected health information on the voicemail or answering machine.

Patient Signature: _____ **Date:** _____

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Name: _____ **Date:** _____ **Age:** _____
Height: _____ **Weight:** _____ **Dominant hand:** ____**Right** ____ **Left**
Reason for visit:

_____
_____
_____

Occupation: _____
Have you seen a physician in the last 6 months: ____ **YES** ____ **NO**
If yes, Name the physician and what condition you were treated for: _____

_____
_____

Allergies (food /Drugs / others): _____
_____

If yes, please explain: _____
_____

Medications: _____
_____

Surgical History

Type of Surgery: _____
Date: _____ **Hospital:** _____

Medical History

	YES	NO	If yes, Describe:
Arthritis	_____	_____	_____
Blood Pressure	_____	_____	_____
Circulation	_____	_____	_____
Heart	_____	_____	_____
Liver	_____	_____	_____
Lungs	_____	_____	_____
Thyroid	_____	_____	_____
Tuberculosis	_____	_____	_____
Are you HIV positive?	_____	_____	_____
Do you Smoke?	_____	_____	_____
Substance Abuse	_____	_____	_____
Other	_____	_____	_____

Patient Signature: _____ **Date:** _____

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How did you hear about or practice: _____
Referring Physician: _____ **Phone:** _____
Primary Physician: _____ **Phone:** _____

Patient Information (Please Print)

First Name: _____ **M.I.:** _____ **Last Name:** _____
Address: _____
Street City State Zip Code
Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____
Date of Birth: _____ **Social Security:** _____ **Sex:** _____ **Male** _____ **Female**
Email address: _____
Marital status: _____ **Single** _____ **Married** _____ **Divorced** _____ **Widowed**

Employment status: _____**Employed** _____**Unemployed** _____ **Retired**
Employer: _____
Employer address: _____

Type of injury you are being treated for: _____**Work Related** _____**Auto Accident** _____ **Sports Injury**
Other _____

Primary Insurance Company Name: _____ **Phone:** _____
Policy Number: _____ **Group Number:** _____
Policy Holder Name: _____ **Date of Birth:** _____
Social Security Number: _____ **Relationship to patient:** _____

Second Insurance Company Name: _____ **Phone:** _____
Policy Number: _____ **Group Number:** _____
Policy Holder Name: _____ **Date of Birth:** _____
Social Security Number: _____ **Relationship to patient:** _____
Workers Comp/ auto Insurance Company Name: _____
Address for Claims: _____
Street City State Zip Code
Adjuster Name: _____ **Phone/ Fax Number:** _____

Emergency Contact (not in the same household) _____ **Relationship:** _____
Phone: _____ **Address:** _____

I do hereby consent to any medical care which is deemed advisable or necessary by my physician and grant authority to Dr. Caban, to administer and perform all examinations, treatments, diagnostic procedures, and surgeries needed now or in the future. I guarantee payment for all services rendered. All medical benefits including major medical benefits, private insurance and any other health plan, are assigned to Dr. Caban. The signature below confirms all of the information provided herein is true and accurate. Photocopy of this consent is to be considered as valid as the original.

Signature: _____ **Date:** _____