JEFFREY E. MILLER, D.P.M.
1340 DeKalb Street, Suite 6B
Norristown, PA 19401-3434

2023 PATIENT INFORMATION

(PLEASE PRINT CLEARLY)

Patient Name	Social Security #
Date of Birth	Home Phone Cell Phone
Street Address	City/State/Zip
Email address	Employer Occupation
Insurance Company (1st) _____ Policy #_____ Group #_____Effective Date_____ Name/Relationship of Insured (if other than self) _____	Insurance Company (2nd) _____ Policy #_____ Group #_____Effective Date_____ Name/Relationship of Insured (if other than self) _____
Primary Care Physician/location	Date of last exam
Pharmacy name (location/phone #)	Emergency Contact/Parent/Guardian & phone #
How did you hear about us?	Height Weight Shoe size
Marital Status:	Spouse Name:
Medications	Prior surgery/date
Do you smoke ? Y N Do you drink alcohol? Y N	Allergies

Illnesses (Circle all that apply)

Anemia	Diabetes	High Cholesterol	Poor Circulation
Arthritis	Gout	Kidney Problems	Rheumatic Fever
Asthma	Heart Disease	Liver Disease	Stroke
Back Pain	Hepatitis	Lung Problems	Thyroid Disorder
Bleeding Disorders	High Blood Pressure	Neck Pain	Other
		Numbness in feet	

CONSENT

I certify that the information above is true and correct to the best of my knowledge. I give consent to the doctor to examine and perform procedures considered necessary and proper in diagnosing and treating my condition.

SIGNATURE: _____ DATE:_____

Please thoroughly read each policy, initial next to each policy and sign below:

Release of Information

____ For the purpose of payment, I allow Dr. Jeffrey E. Miller to release my Private Health Information to any and all of my insurance carriers, their third party payors and claim reviewers, until the claim is resolved. For the purpose of treatment, I also allow the above listed practice to release my information or contact any and all of my treating physicians.

Acknowledgement of Receipt of Notice of Privacy Practices

____ I acknowledge that I was provided a copy of the HIPAA Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice. The BDFA HIPAA rights are distributed to each patient.

Patient Financial Policy

____ You are responsible for all authorizations/referrals/precerts needed to seek treatment with Dr. Jeffrey E. Miller.

____ Your portion of payment for ALL office services is due **at the time of service.** We will accept VISA, MasterCard, cash or check.

____ Please honor our 24 hour reschedule notice, as there may be a charge for appointments broken or cancelled without 24 hours advanced notice.Repetitive broken or cancelled appointments and/or non-compliance may result in transfer of your care to an alternative practice.

____ We have made prior arrangements with insurers and other health plans to accept an assignment of benefit. We will bill those plans with which we have an agreement and will require you to pay the co-pay/co-insurance/deductible at the time of service. If you are seeing our doctors on an "Out of Network" basis, you will be subject to out of network rates.

____ Our office does not file to secondary insurance unless the patient has Medicare. For all other insurances, we will provide an itemized statement upon your request. If you possess two insurance plans, you MUST notify us of your designated PRIMARY policy.

____ We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Any payment exceptions will be agreed upon in writing.

____ PAST DUE accounts are subject to collection proceedings including the credit bureau. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

____ There is a service fee of $25.00 for all returned checks. Upon an NSF or CLOSED ACCOUNT occurrence, all future remittances will need to be in other forms of payment. Restitution of "Theft-By-Check" will be requested from the District Attorney's Office.

____ ONLY UNWORN and NON-custom items are returnable within 3 days of receipt.

____ I give permission to the office of JEFFREY E. MILLER, DPM and/or their agents to contact me on any telephone number associated with my account, including cell phone number(s), as well as e-mail.

Authorization of Payment

____ I hereby assign all Medical benefits directly to Dr. Jeffrey E. Miller for the payment of any services rendered. I also authorize release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay for the services I received, I will be financially responsible for payment.

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

Patient's Name: _____ Signature of Patient/Guardian _____ Date: _____

Office Witness: _____ Date: _____ _____Patient initials to indicate copy received

In case of emergency, please contact the following individual(s):

Name_____ Relationship _____Telephone Number _____