



Tanya R. Sellers-Hannibal, DPM, PC

Podiatric Medicine & Surgery

Welcome to our office!

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

The Physicians' Pavilion @ Owings Mills

10085 Red Run Blvd. - Suite 305

Owings Mills, MD 21117

Tel 410.581.8331 • Fax 410.581.8332

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 ____

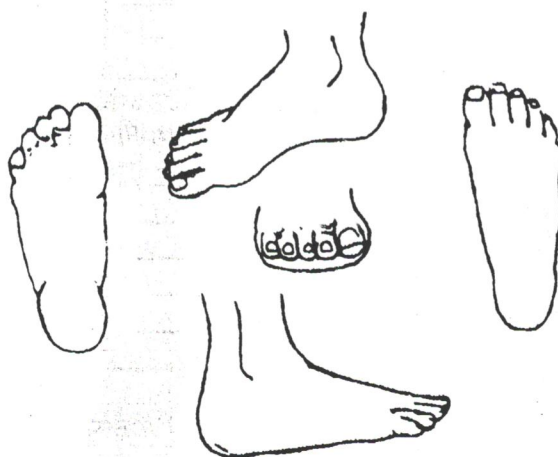
Name (if doctor or family/friend): _____

PLEASE COMPLETE REVERSE SIDE. THANK YOU!

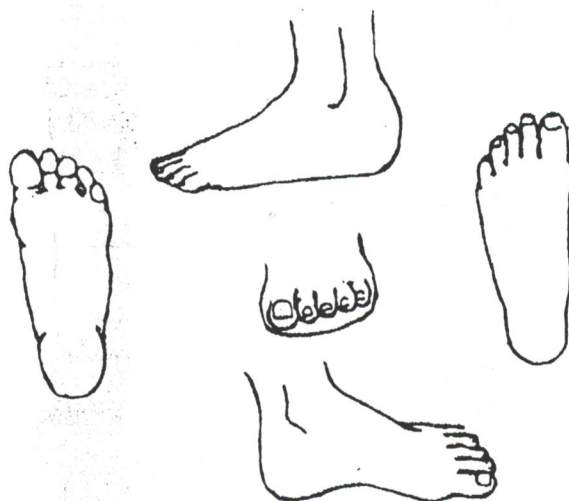
What problems bring you to our office:

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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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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Thank you!

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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.
- There is a \$25.00 cancellation fee for any appointments not canceled within 24 hours of the scheduled appointment.
- 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

Relationship to Patient (if other than self)



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

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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 _____

Email Address _____ @ _____

Home Phone _____ . _____ . _____

Mobile Phone _____ . _____ . _____

Work Phone _____ . _____ . _____

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

Leave Message With:

Legal Guardian Only _____ Spouse (If applicable) _____

Whoever Answers _____ No One _____

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