Richard M. Hilker, DPM, PC , FACFAS

10323 Dawson's Creek Blvd.
Building 10-C • Fort Wayne, IN 46825
(260) 490-3668 • Fax (260) 490-7574
www.drhilker.com

PATIENT REGISTRATION FORM

Today's Date: _____

PATIENT INFORMATION

Name: _____ Gender: M or F
(Last) (First) (MI)

Date of Birth: _____ Age: _____ SS# _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____

E-mail Address: _____ Cell Phone: _____

Marital Status: S M W D Student Status: Full or Part Time

Employer Name: _____

EMERGENCY AND RESPONSIBLE PARTY INFORMATION

Same as patient: _____

Name: _____ Gender: M or F
(Last) (First) (MI)

Date of Birth: _____ SS# _____ Relationship to Patient: _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____

Employer Name: _____

Is this work or accident related? Yes No Claim#: _____

Name of Insurance/Workman's Comp.: _____

Address: _____

INSURANCE INFORMATION

Name of Primary Insurance: _____ ID#: _____

Name of Insured (Policy holder): _____ SS#: _____

Insured DOB: _____ Relationship to Patient: _____

Employer: _____ Insured Phone Number: _____

Secondary Insurance Company Name: _____ Phone: _____

Name of Insured: _____ Insured DOB: _____ Relationship to Patient: _____

Insured SS#: _____ Employer: _____ Phone: _____

Insured ID: _____ Group#: _____ Prior Authorizaiton needed? Y or N

(PLEASE TURN PAGE OVER FOR ADDITIONAL INFORMATION)

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OFFICE AND FINANCIAL POLICY

Thank you for choosing our practice for your podiatry needs. The information and registration packet that was mailed to you after you made the appointment must be brought to the office completed with your insurance card/s and list of your medications at the time of your appointment. You could also download and copy these forms from our website www.drhilker.com and get directions to our office.

Payment in full is expected at the time of service unless you are covered by health insurance policy. We accept cash, personal checks, debit/credit cards and HSA cards. We accept assignments from Medicare and Medicaid and take most private insurance policies. For HMOs like HUMANA, a referral approval and number is required from your primary care physician or you will not be seen in the office. We participate in some Affordable Care Act plans (Obamacare). It is your responsibility to understand your plan requirements and to obtain the necessary authorization number.

Our Office will file all applicable claims for services to your insurance company and you are responsible for amounts not covered such as deductible, co-payments, co-insurance and out-of-network charges. If you are not able to pay your balance, please contact our billing company at (260) 918-2139 or (866) 918-2139 to make a payment plan and avoid collection proceedings.

I certify that I understand and agree to comply with Richard M. Hilker, DMP, PC Office and Financial Policy.

Signature: _____

Date: _____

HIPPA PRIVACY AUTHORIZATION FORM

I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information (PHI)"

_____ all past, present and future periods.

_____ my complete health records including, those related to mental health care, communicable diseases, HIV and AIDS and treatment of alcohol/drug abuse.

_____ Other (please specify exceptions) _____

In addition, I authorize disclosure of information regarding my billing, health condition, treatment and prognosis to _____.
(relationship)

Signature of Patient: _____ Date: _____

REV. 8-27-14