TORREY RASSFELD DPM, C.PED, FACFAOM
2627 Stockwell St, Lincoln, NE 68502
P: 402/405-5924 F: 402/261-1926

Welcome to our office.

Today's Date: _____

_____ _____ _____ _____ M or F
Patient's Last Name First MI Nickname Gender

_____ _____ _____ _____
Birthdate Social Security # Marital Status Referred By

Address_____City_____State_____Zip_____

Home Phone (___) _____Cell Phone (____)_____ Work Phone (____)_____

Email Address_____**Required for patient portal access to health record**

Employer_____Address_____
Occupation_____

Emergency Contact Information (Outside of Household)
Name_____Address_____
Phone_____ Relationship to Patient_____

Spouse/Parent/Legal Guardian Details
Name_____ Birthdate_____ Phone Number (____)_____
Employer_____ Social Security Number_____
Relationship to Patient _____ Reason Patient Unable to Consent _____

Preferred Language_____ **Race**_____ **Ethnicity**_____

Primary Care Physician _____ Date last seen _____
Pharmacy name and location _____

Insurance Information
Primary_____ Insured's name/birthdate _____
Secondary_____ Insured's name/birthdate _____
Tertiary_____ Insured's name/birthdate _____

Accident/Injury/Worker's Compensation
Date of Accident/Injury _____Type of accident/injury_____
Is this a worker's compensation claim? ____Yes ____No
If yes, please provide the name, address of the worker's compensation insurance company _____
_____
Claim number_____ Adjuster's name _____ Phone number _____

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I have read and understand the Rassfeld Foot and Ankle Financial Policy form and I agree to its terms and conditions.

PATIENT (OR REPRESENTATIVE) SIGNATURE _____ DATE _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Rassfeld Foot and Ankle to release any and all information from my medical record including information concerning medical and hospital records, and not exclusive of information regarding psychiatric or mental health treatment, tobacco, alcohol or drug abuse, cancer, AIDS/HIV related information, and other communicable disease related information for the completion and processing of all claims for services and treatments. I understand that my medical record contains information which includes, but is not limited to, any medical condition I have had in the past, now have, or may have in the future, presenting symptoms and complaints, any histories, findings on examination, medical treatment, hospitalization, bills, financial information, operative reports, lab test results, x-rays and reports, diagnostic tests and reports, consultative reports, daily progress reports or notes, and medications.

If my insurance benefits are provided to me through Medicare, I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other insurance" is indicated in item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

I understand that my medical record is confidential and that I may refuse authorization to disclose all or some of the information contained therein, but that refusal may result in denial of coverage or claim for health benefits or other insurance.

I release Rassfeld Foot and Ankle from any and all legal responsibility or liability that may arise from the act I authorized above.

PATIENT (OR REPRESENTATIVE) SIGNATURE _____ DATE _____

ASSIGNMENT OF INSURANCE BENEFITS

I assign to Rassfeld Foot and Ankle all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize direct payment of all such insurance benefits to Rassfeld Foot and Ankle and agree to pay for any and all charges not paid pursuant to this agreement. If my insurance benefits are provided to me through Medicare, I hereby authorize and assign any and all reimbursement pertaining to said services to be made on my behalf and paid directly to Rassfeld Foot and Ankle. I authorize the use of this signature on all insurance submissions.

PATIENT (OR REPRESENTATIVE) SIGNATURE _____ DATE _____