MERCURY PODIATRY, INC.
Dr. Paul F. Haluska
4201 Edgmont Avenue
Brookhaven, PA 19015
Phone: 610-874-8431
Fax: 610-874-8288

Thank you for choosing me as your Podiatrist. I have been practicing podiatric medicine in Delaware County since 1976. I was incorporated as Mercury Podiatry Inc. in 1978. You can be assured that I will apply all my expertise from my many years of experience to gently caring for all your foot problems.

Please find three documents to be filled out in preparation for your initial office visit.

The "Signature on File" form allows me to bill your insurance company for services rendered and for them to pay me directly.

The "Patient Financial Responsibility" form states that you accept the ultimate responsibility for payment of my services.

Read these two documents carefully before signing and dating where indicated. If you do not understand something or have any questions please call my office to speak to me for a thorough explanation.

The "Demographics" form needs to be completed with your personal information, medical history, allergies and medications. In order to prevent errors in billing, please be sure to bring all insurance cards with you.

I abide by the HIPPA security law for personal and medical information. I do not give, sell or otherwise dispense any of your information to a third party without your permission or through legal recourse.

I look forward to meeting you very soon.

Paul F. Haluska, DPM

Today's Date: ______________________

Name ______________________

Address ______________________

____

E Mail: ______________________

Guardian / Billing Name ______________________

Billing Address ______________________

____

____

Phone: Home __________ Work __________

Date of Birth: __________ Age ______ Wt. ______ Shoe Size ______

Male __________ Female __________

Emergency Contact: __________ PH# __________

Marital Status: ______________________

Spouse's Name: ______________________

Physician's Name: ______________________

Address / Phone: ______________________

____

____

Occupation: ______________________

Employer: ______________________

Payment Plan: Cash / Ins. Co. ______________________

Referred By: ______________________

Major Complaint: ______________________

____

____

____

Duration: ______________________

Previous Illnesses / Hospitalization / Injuries:

____

____

____

Previous Medical History:

Illnesses

(Self)		(Family)
( )	Anemia	( )
( )	Arthritis	( )
( )	Asthma	( )
( )	Cancer	( )
( )	Diabetes	( )
	• Onset: __________	
( )	Epilepsy	( )
	• Last Seizure __________	
( )	Gout	( )
( )	Heart Disease	( )
( )	Hypertension	( )
( )	Kidney Disease	( )
( )	Liver Disease	( )
( )	Peripheral Vascular Disease	( )
( )	Tuberculosis	( )
( )	Other __________	( )
( )	__________	( )

Allergies

(Self)		(Family)
( )	Aspirin	( )
( )	Codeine	( )
( )	Cortisone	( )
( )	Iodine	( )
( )	Mercurochrome	( )
( )	Merthiolate	( )
( )	Novacaine	( )
( )	Penicillin	( )
( )	Sulfa	( )
( )	Tape	( )
( )	Other __________	( )
( )	__________	( )
( )	None Admitted	( )

Medications:

____

____

____

____

____

____

____

____

Codes: (M) Mother (F) Father (S) Sister
(B) Brother (A) Aunt (U) Uncle
(GM) Grandmother (GF) Grandfather

Alcohol:	Yes	No
Diet Pills:	Yes	No
Tobacco:	Yes	No
Tranquilizers:	Yes	No

Other: ______________________

MERCURY PODIATRY INC.
Dr. Paul F. Haluska
4201 Edgmont Ave.
Brookhaven, Pa. 19015
Phone: 610-874-8431
Fax: 610-874-8288

PATIENT FINANCIAL RESPONSIBILITY FORM

Patient Name____

Chart No: ____________

Due to cost sharing initiatives by insurance companies, very few insurance plans cover the entire cost of treatment.

It is the obligation of the patient to determine the extent of his/her insurance coverage.

Please be aware that you may be financially responsible for a portion of the fee for the foot care received in this office.

This office will not contact your insurance company to determine your coverage.

I,____________________________________have read, understand and agree to the above statements and consent to treatment by Dr. Haluska.

Signed____________________________________Date____________________
(Person Responsible for Account)

Signed____________________________________Date____________________
(Witness)

MERCURY PODIATRY INC.
Dr. Paul F. Haluska
4201 Edgmont Ave.
Brookhaven, Pa. 19015
Phone: 610-874-8431
Fax: 610-874-8288

SIGNATURE ON FILE FORM

___I authorize the doctor named above to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.

___I authorize release of any information related to any claims to all my Insurance Companies or other relevant parties.

___I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me.

___I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.

___I authorize payment of health benefits otherwise payable to me, directly to my doctor.

___I permit a copy of this authorization to be used in place of the original.

___This "Signature On File" is valid for all future services provided by Dr. Haluska.

____
Signature of Beneficiary, Guardian or Personal Representative

_______________________ _______________________
Medicare No. (If applicable) Date

____
Please print name of Beneficiary, Guardian or Personal Representative

____
Relationship to Beneficiary