

JAMES S. SCALES, DPM  
WILLIAM F. HINESER, D.P.M., P.C.

Welcome to our office. Please answer the following questions to help us become better acquainted and to provide you with the best possible care. If you require any help please ask us.

MR-MRS-MS \_\_\_\_\_ Date of Birth \_\_\_\_\_

By what name do you wish to be called? \_\_\_\_\_

Address \_\_\_\_\_ Home Phone (    ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone (    ) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Business Address \_\_\_\_\_

Spouses Name \_\_\_\_\_ Occupation \_\_\_\_\_

Spouses Employer \_\_\_\_\_ Phone (    ) \_\_\_\_\_

Person Responsible for Payment \_\_\_\_\_

Family Physician \_\_\_\_\_ Last Visit \_\_\_\_\_

Medical Insurance \_\_\_\_\_

Social Security Number \_\_\_\_\_

E-Mail Address (will not be shared- you will receive our news letter) \_\_\_\_\_

Former Podiatrist \_\_\_\_\_ Last Visit \_\_\_\_\_

How did you learn about our office? \_\_\_\_\_

I hereby acknowledge and agree that any account that becomes delinquent will be subject to collections service. I agree to pay all court costs and reasonable attorney fees for collection of all past due amounts owed, plus interest thereon at 18% per year on all such amounts outstanding. There is a \$20.00 service charge will be made on all returned checks. Additional charges will be made for cost of collection.

With the exception of participating insurance plans, any insurance is a contract between you and your insurance company. We do not set the amount or even determine if payment will be made. I agree that fees for services rendered are my responsibility regardless of the action of my insurance company. I agree that information may be sent to or received from my family doctor. I authorize my insurance company to make payments directly to William F. Hineser, DPM, PC./James S. Scales, DPM

MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made on my behalf to William F. Hineser, D.P.M./James Scales DPM.; for any services furnished me by Dr. Hineser and/or Dr Scales or there agents. I authorize Dr. Hineser/Dr. Scales to release any necessary medical information about me to the Centers for Medicare & Medicaid Services and its agents as needed.

ALL PATIENTS PLEASE SIGN: \_\_\_\_\_ Date: \_\_\_\_\_