PATIENT INFORMATION FORM

Please Print

Is your visit related to an injury at work? □ No □ Yes Today's Date: _____

Name: _____
First Middle Initial Last

Date of Birth: _____/_____/_____ Age:____ Social Security # : _____-_____-_____ Sex: □ Male □ Female
MM DD YYYY

Marital Status: □ Single □ Married □ Widowed □ Divorced If Married, Spouse's Name: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____)_____ Cell Phone # : (_____)_____

Phone # to use for Confirmation of Appt: (____)_____ E-Mail: _____

Employer Name: _____Phone # : (_____)_____

Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician's Name: _____ Phone # : (_____)_____

Pharmacy Name: _____ Phone # : (_____)_____

Pharmacy Address: _____ City: _____ State: _____ Zip: _____

In case of emergency, name & phone number of nearest relative: _____ (____)_____

Financial / Responsible Party Information – <u>MUST</u> be completed:

Guarantor Name: _____Relationship to Patient: □ Self □ Spouse □ Parent
First Middle Initial Last

Date of Birth: _____/_____/_____ Social security # : _____-_____-_____ Sex: □ Male □ Female
MM DD YYYY

Employer Name: _____Phone # : (_____)_____

Employer Address: _____ City: _____ State: _____ Zip: _____

Drivers License # : _____ State:_____

Insurance Information – <u>MUST</u> be completed:

<u>Primary Insurance:</u>

Insurance Carrier: _____ Policy / ID # : _____Group # : _____

Policy Holder: _____ Relationship to Patient: □ Self □ Spouse □ Child

DOB: _____/_____/_____ Insured SS # : _____-_____-_____ Employer: _____
MM DD YYYY

<u>Secondary Insurance:</u>

Insurance Carrier: _____ Policy / ID # : _____Group # : _____

Policy Holder: _____ Relationship to Patient: □ Self □ Spouse □ Child

DOB: _____/_____/_____ Insured SS # : _____-_____-_____ Employer: _____
MM DD YYYY

<u>Other Insurance:</u>

Insurance Carrier: _____ Policy / ID # : _____Group # : _____

Policy Holder: _____ Relationship to Patient: □ Self □ Spouse □ Child

DOB: _____/_____/_____ Insured SS # : _____-_____-_____ Employer: _____
MM DD YYYY

Signature of Patient / Responsible Party: _____ **Date:** _____

[Revised 10/2009]

History & Medical Information

1. **Explain your foot/ankle problem** ☐ Right ☐ Left _____

_____

2. **When did pain/discomfort begin (date):** _____

Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other _____

3. **What makes the pain/discomfort better:** _____

4. **Have you had a physical trauma?** ☐ No ☐ Yes _____

5. **Have you had an accident?** ☐ No ☐ Yes _____

6. **Occupation:** _____ **Is your problem work related?** ☐ Yes ☐ No

7. **Are you currently pregnant?** ☐ No ☐ Yes _____

8. **Past Medical History:**

☐ Anemia	☐ Gout	☐ Thyroid Disorders	☐ Osteoarthritis
☐ Bleeding Disorders	☐ Heart failure	☐ Lung/Respiratory Disorders	☐ Other Arthritis
☐ Cancer _____	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Rheumatic Fever
☐ Diabetes	☐ High Cholesterol	☐ Nerve Disorders	☐ Stroke
☐ Epilepsy	☐ HIV / AIDS	☐ Neurological Disorders	☐ Kidney Disease
	☐ High Blood Pressure	☐ Prostate Disorders	☐ Other: _____

9. **List all medications/herbs/vitamins:** ☐ **NONE** _____

_____

10. **Allergies:** (Describe reaction) ☐ **NONE**

☐ Penicillin _____ ☐ Aspirin _____ ☐ Narcotic Agent / Codeine _____
☐ Anesthesia _____ ☐ Shellfish _____ ☐ Sulfa Drugs _____
☐ Nickel / Metal _____ ☐ Radiographic Contrast Dye _____
☐ Other _____

11. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No

Surgery / Date: _____

_____

12. **Social History:** (Only check what is pertinent to you)

☐ Tobacco Use ☐ Alcohol Use ☐ Exercise habits_____
☐ Caffeine Use ☐ Drug use (recreational, IV)

13. **Family History: (List relationship of family member(s) who have had these problems):**

☐ Diabetes_____ ☐ Heart Disease _____ ☐ Kidney Disease _____
☐ Hypertension _____ ☐ Stroke _____ ☐ Mental Illness _____
☐ Rheumatology _____ ☐ Bleeding Disorders _____ ☐ Cancer _____
☐ Other family History: _____

14. **Height:** _____ **Weight:** _____ **Shoe size:** _____

For office use: B/P _____ Pulse _____ Resp. _____ Temp. _____

Review of Systems

Please check any of the following that you are **currently experiencing** or have **recently experienced.**

Constitutional			
☐ Fever	☐ Chills	☐ Sweats	☐ Weight Change
Head, Eyes, Ears, Nose and Throat			
☐ Wear Contact Lenses	☐ Dentures	☐ Wearing Eyeglasses	
☐ Double Vision	☐ Cataract	☐ Dizziness	
☐ Difficulty Swallowing	☐ Neck Pain	☐ Sore Throat	
☐ Nosebleeds	☐ Problems with eyesight	☐ Ringing in the Ears	
Cardiovascular			
☐ Chest Pain / Discomfort	☐ Cardiovascular Symptom	☐ Heart Murmur	
☐ Swelling lower extremity	☐ Leg Pain with Exercise	☐ Palpitations	
Hematologic/Lymphatic			
☐ Bleeding Problem	☐ Swollen Glands	☐ Lymphoma	
☐ Anemia	☐ Skin Lump - Location		
Respiratory			
☐ Difficulty Breathing	☐ Wheezing	☐ Previous Pulmonary Disease	
☐ Exposure to TB	☐ Cough	☐ Pulmonary Symptoms	
Gastrointestinal			
☐ Nausea	☐ Vomiting	☐ Diarrhea	
☐ Decrease in Appetite	☐ Abdominal Pain	☐ Constipation	
Endocrine			
☐ Often Thirsty	☐ Frequent Urination	☐ Thyroid Disease	
☐ Urinary Symptoms	☐ Prostate Problems	☐ Prior Kidney Disease	
Musculoskeletal			
☐ Musculoskeletal symptoms	☐ Feeling weak	☐ Join Pain, Arthralgia	
☐ Weakness of limbs	☐ Prior Fracture		
Nervous System			
☐ Ataxia	☐ Speech Difficulties	☐ Headache	
☐ Neuropathy	☐ Confusion/ Disorientation	☐ Fainting	
☐ Convulsions			
Skin			
☐ Rash	☐ Ulcer	☐ Lesions	☐ Sun Sensitivity
☐ Color Change	☐ Slow Healing	☐ Infections	☐ Cracking
☐ Eczema (Pruritus)	☐ Growth	☐ Hair Loss	
Allergic, Immunologic History			
☐ Dermatitis	☐ Rheumatoid Arthritis	☐ Lupus	☐ Collagen Vascular
Psychiatric			
☐ Nervousness	☐ Tension	☐ Depression	

Late Cancellation & No-Show Policy

Effective July 1, 2014

Family Foot*care* has adopted a very clear and strict late cancellation & no-show policy. Failure to contact Family Foot*care* prior to your scheduled appointment will result in a ***$50 fee***. This fee must be paid in advance before any further appointments will be scheduled. Insurance companies will not pay this charge and it will be YOUR (patient and or guardians) responsibility. We do not introduce this policy lightly but feel it is in the best interest of ALL our patients, as late cancellations and no-shows effect other patients and physicians as well.

Medicaid patients: Please be aware that per Medicaid regulations we cannot charge for late cancellation & no-shows, but we can and will discharge you from the practice.

All patients receive appointment reminders for visits scheduled at our practice. Our practice utilizes an automatic appointment reminder system that emails (if an email was provided) 4 days prior to your visit, texts (if a cell number was provided) your cell phone 3 days prior to your appointment and calls the home number you provided 2 days prior to your scheduled visit. It is the patient's responsibility to make sure that these appointments are kept. ***Please understand that these are courtesy reminders. It is still YOUR (patient and or guardians) responsibility to arrive at appointments as scheduled or cancel appropriately*** as outlined above.
Please know that last minute cancellations & no-show visits are recorded in patient files. Continued cancellations and/or missed appointments may result in discharge from our practice.

I have read and I understand this policy.

Patient's Name: _____ Date of Birth: _____

_____ Date: _____

Patient and/or Guardian's Signature

Family Footcare, PC

PATIENT FINANCIAL POLICY

Thank you for choosing Family Footcare, PC for your podiatric care. Our doctors and staff are committed to providing quality, affordable medical care without regard to financial status.
We sincerely hope that by sharing our financial expectations we will strengthen the practice-patient relationship and keep the lines of communication open. This financial policy helps the practice provide quality care to our valued patients. If you have any questions or need clarification of any of the policies, please feel free to contact our office at (203) 723-7884.

Self-Pay Accounts

We designate accounts, **Self-Pay**, under the following circumstances: (1) patient is covered by an insurance plan that our providers do not participate in, (2) patient does not have a current, valid insurance card on file, (3) patient does not have a valid insurance referral on file, or (4) patient does not have health insurance coverage.

Payment is Due At the Time of Service

- We accept cash, checks, debit, and credit cards.
- All co-payments, deductibles and non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment.
- Insurance required co-payments are due when you check in for your appointment. If you arrive without your co-payment, we may ask you to reschedule.
- If your co-payment is based on a percentage (example: 20% of the allowed amount) and you do not have a secondary policy, please be prepared to pay a minimum of $10.00 on the date of service.
- Patient-responsible balances are due when you check in for your appointment.
- In the event you need surgery and you do not have health insurance coverage, we must receive payment in full prior to surgery. If a deductible is applicable, it will also be due prior to surgery.

Proof of Insurance

- Please bring your insurance card(s) with you to each appointment.
- It is your responsibility to inform the reception staff when the cause of treatment may be the responsibility of a third party - auto insurance, liability insurance company, worker's compensation - instead of your regular health insurance carrier. You are responsible to provide the office with all information required to bill the third party when you check in for your appointment.
- We will bill your insurance company or companies for you. Should any of your insurance companies reimburse you directly, we expect payment from you – in full – within 10 days of the receipt of payment. The patient or responsible party is ultimately responsible for payment of any charges incurred.

Referrals

- If your insurance plan has a designated primary care physician (PCP) and you are required to obtain a written referral from that doctor, you must provide the office with that written referral at the time of check-in. If you do not have a current, valid referral, we may ask you to either reschedule your appointment or pay for the visit at the time of service.

Our Responsibility to Report Non-Compliance

- It is our obligation under many of the insurance contracts to report patients who: repeatedly refuse to pay co-payments/deductibles at time of service, or who repeatedly "no show" for appointments.

Financial Assistance

- Our practice treats patients regardless of financial status. We offer assistance in the form of our affiliation with CareCredit, a healthcare credit card program.

Divorce and Child Custody Cases

- In cases of divorce, the individual who receives care is responsible for payment of co-payments, coinsurance, deductibles, and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.
- The parent who brings the child to the office for care is responsible for payment at the time of service no matter if the account is self-pay, participating insurance, or nonparticipating insurance. The practice does not honor divorce specifics (e.g., percentage of financial responsibility).
- If the child has coverage with a participating insurance plan and the proper insurance identification is present at the time of service, the practice will bill that insurance company. Applicable co-payments, coinsurance and/or deductibles are due at the time of service, unless arrangements have been made with the office prior to arrival.

Billing, Payments and Refunds

- All balances are due in full within 30 days of the statement date.
- If you cannot pay the balance in full with 30 days, please contact our office to set up a payment plan or discuss financial assistance.
- It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same financial responsible party.
- We reserve the right to report delinquent accounts to credit bureaus, assess a collection or returned check fee, take other collection action, or terminate you as a patient of this practice.

I have read the Patient Financial Policy and agree to abide by its terms.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____
Patient or Legal Guardian

Written Acknowledgement of Receipt
Of Notice of Privacy Practices

I acknowledge that I have received a copy of Family Footcare's Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

Internal Use Only:

If the patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to the patient/representative and sign below.

Presented on (date and time): _____

By (name): _____

Family Footcare, PC
1183 New Haven Rd, Naugatuck CT 06770 · Phone (203) 723-7884 · Fax (203) 723-2946
52 Federal Rd, Unit 1A, Danbury CT 06810 · Phone (203) 792-3668 · Fax (203) 796-7478
77 Main St North, Ste 104, Southbury CT 06488 · Phone (203) 405-6501 · Fax (203) 405-6504

Authorization Request Form
For Use and Disclosure of Patient Health Information

In completing this form, you are authorizing the use and disclosure of your Protected Health Information.

Requested Authorization (please provide specific details and dates):

_____

_____

Information may be released to: (please specify name of person)

□ **Spouse:** _____

□ **Parent:** □ **Mother** □ **Father** □ **Both:** _____

□ **Child(ren):** _____

□ **Attorney:** _____

□ **Physician (please specify):** _____

□ **Other (please specify):** _____

Patient Name (Please print): _____
Patient Date of Birth: _____

Signature of Patient or
Authorized Representative: _____

Relationship (if other than patient signing): _____

Date: _____

FOR OFFICE USE ONLY

Accepts [ ] Denies [ ]

Reason: _____

Privacy Officer Signature: _____

Date: _____

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