PATIENT INFORMATION

Patient Name: _____DOB: _____Age: _____ Today's Date: _____

Home Address: _____ Gender: M ____ F ____ Other ____

City: _____ State: _____ Zip _____ _____

Phone #'s: Home / Cell (_____) _____-_____ Email address: _____

Employer: _____ Job Title: _____

Who referred you to our office? _____

Primary Care Physician **(first and last name)**: _____

Pharmacy: _____ Location: _____

INSURANCE INFORMATION

Primary insurance: _____ Insurance ID #:_____

Policy Holders Name: _____ DOB: _____

Secondary insurance: _____ Insurance ID #:_____

Policy Holders Name: _____ DOB: _____

Social Security #: _____- _____- _____

Describe your foot/ankle problem in detail:

_____

_____

_____

_____

Has this problem been previously treated? Yes ___ No ___ If yes, by whom? _____

Is this Workman's Comp? Yes / No Date and place of injury: _____

Authorization and Release

I authorize the release of any medical information to any healthcare professional, or if necessary to process my medical billing claims. I also authorize payment of medical benefits to physicians for the services rendered by them.

_____ _____ _____

Signature/ Responsible Party **Relationship** **Date**

MEDICAL INFORMATION/ HISTORY

Please list your:
Height: _____ Weight: _____ Shoe Size: _____

Medical conditions: _____

_____

_____

Previous hospitalizations and/or surgeries: _____

_____

_____

Current Medications: _____

_____

_____

Medication Allergies: _____

_____

Family Medical History: _____

_____

Social History:
Do you smoke? Yes / No If yes, how many cigarettes per day? _____ # of years? _____
Do you drink alcoholic beverages? Yes /No If yes, Rarely ____ Social ____ Daily ____ Heavy _____
Do you exercise regularly? Yes / No If yes, what activities do you enjoy? _____
Marital Status: Single_____ Married_____ Divorced ____ Widowed ____ Number of children _____

Do you have/ have you had any of the following health problems:

Bleeding tendency	Y	N	Stroke/ paralysis	Y	N	Staph Infections/MRSA	Y	N
Diabetes	Y	N	Phlebitis/ blood clots	Y	N	Non- healing ulcers	Y	N
Thyroid disease	Y	N	GI issue/ ulcers	Y	N	Asthma	Y	N
Arthritis/ gout	Y	N	Kidney disease	Y	N	Periodontal disease	Y	N
Epilepsy/ Seizures	Y	N	Liver disease/ hepatitis	Y	N	Auto-immune disorder	Y	N
High blood pressure	Y	N	Lung disease	Y	N	Lyme disease	Y	N
Heart issues/ murmur	Y	N	Cancer/ tumor	Y	N	HIV (AIDS) concerns	Y	N
Osteomyelitis / bone infections	Y	N	Nervous / emotional disorder	Y	N			

Review of Symptoms: Do you have or have you had:

Weight changes in the last year	Y	N	Swollen glands/unusual lumps	Y	N
Serious problems with eyes/ears	Y	N	Stomach/ abdominal pains	Y	N
Wear glasses/contacts	Y	N	Frequent nausea/ vomiting	Y	N
Chest pains/ tightness	Y	N	Frequent constipation/ diarrhea	Y	N
Shortness of breath/ cough	Y	N	Excessive thirst	Y	N
Difficulty swallowing	Y	N	Frequent urination	Y	N
Frequent headaches	Y	N	Cholesterol problems	Y	N
Ankle/ leg swelling	Y	N	Fatigue/ tiredness	Y	N
Joint or back pain/ swelling	Y	N	Fractured/ broken bones	Y	N

OFFICE POLICY REGARDING HEALTH INSURANCE/FINANCIAL AGREEMENT/GENERAL CONSENTS/AUTHORIZATIONS

The doctors and staff of the Foot & Ankle Institute of New England welcome you as a patient and are pleased that you chose us to provide you with your foot and ankle care. We have advised you that we do not participate in all insurance programs and that certain services in some cases are not covered by insurances. We reserve the right to perform services and utilize certain professional staff to assist us in your care regardless of your insurance coverage.

Additionally, our office policy is to receive payment at the time services are rendered to you. If you are not prepared to make your co-pay or other patient financial responsibility amounts, you may incur additional fees and/or your visit may be rescheduled. It is imperative that you fully understand what your financial responsibilities are because you are ultimately responsible for paying for all services vended to you. If you are not familiar with your coverage it is strongly recommended that you contact your insurance carrier directly and be made aware of what financial obligations you have at all times. Our services are rendered to you, not to the insurance company. You have final responsibility to see that all services are paid. The Foot & Ankle Institute of New England will be happy to file your primary insurance claim for you and please be sure that we have all of the proper information in order to execute this process. Any additional forms which may be required are your responsibility to secure and you are to complete and sign it before providing it to us. If you have additional insurance coverage, please be aware that we do not file through most secondary carriers. We will file to your secondary carrier if we are in their network. If you receive a bill from the Foot & Ankle Institute of New England with a balance and you have a secondary carrier, this means that we do not file out to that insurance company as a secondary payer and it is your responsibility to do so. Again, it is your responsibility to call your insurance company with any corrections regarding your coverage. If you plan requires you to obtain referrals to specialists, please comply with this requirement and see that you have all the necessary documentation prior to your visit.

You will be required to follow all registration procedures which may include updating and verifying personal information and presenting verification of current insurance at each visit. Your card or other insurance verification must be on file in order for your insurance to be billed. If we do not have your insurance card on file or we are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self pay patient, our fee is expected to be paid in full at the time of service. A finance charge may be placed on all past due accounts and a twenty-five dollar ($25.00) fee will be charged on any returned check. In the event of nonpayment of an account, understand that you are ultimately responsible for all collection costs to include reasonable attorney fees, incurred for the collection of said balance.

I hereby give the Foot & Ankle Institute of New England consent for those services deemed medically necessary and appropriate by the attending provider. I request that payment of authorized Medicare or any other insurance benefits be made on my behalf to the Foot & Ankle Institute of New England {FAINE} for any services provided to me by this group. I understand that any holder of medical information about me may release any information to the healthcare finance administration and its agents in order to facilitate reimbursement for services rendered. I authorize FAINE to release information to all parties/or their representatives listed on my patient information sheet or that may be required to provide or pay for services rendered.

I understand that the above consent/authorization do not guarantee payment/reimbursement nor does it release me from any obligation or responsibility for outstanding charges not covered as a result of, but not exclusive to; Copayments, Co-Insurance, Deductibles, Usual and Customary Schedules, Maximum Allowances/Limits or non-covered services.

I understand that it may be necessary to use a photocopy of facsimile of this assignment and that is to be considered as valid as the original.
I understand and agree to the above statements. I authorize payment of medical benefits to the Foot & Ankle Institute of New England and its physicians for services provided to me, or any member of my family covered under my insurance plan.

I authorize release of any medical or other information necessary to process my medical claims.

Patient/Guarantor: _____/Signed by: _____/Date:_____

The signature above indicates they have read the above statement and agree to accept its terms and conditions.

Robert E. Gallucci, DPM Candace Criscione, DPM Stephen J. Rogers, DPM

HIPAA COMPLIANCE PATIENT CONSENT AND MEDICAL PRIVACY POLICY

All patient information if confidential and every attempt will be made to respect confidentiality when communicating with patients. Patients will be informed of this policy upon entering this practice and yearly thereafter. It is our policy to release patient information to other providers with written and/or oral patient consent. Only the patient themselves may call for test results unless they have authorized the Foot & Ankle Institute of New England to provide information to family/guardian members.

Our notice of privacy practices provides information of how we may use or disclose protected health information. The notice contains a patients' rights section describing their rights under the law, you ascertain that by your signature acknowledging you have reviewed our notice before signing this consent. The terms of the notice may change and if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment of healthcare operations. We are not required to agree with these restrictions but if we do, we shall honor this agreement. The Health Insurance Portability and Accountability Act of 1996, {HIPAA} law allows for the use of information for treatment, payment or healthcare operations.

By signing this form, you provide consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, and signed by you however; such revocation will not be retroactive.

By signing this form, I understand:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has a right to restrict the use of the information but the practice DOES NOT have to agree to those restrictions.
- The patient has a right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- At times, the office may need to contact you regarding test results, insurance claims and/or to confirm an appointment.
- If we call and you are not available:
  - May we leave a message on your answering machine or on your cell phone at home? Yes _____ No _____
  - May we leave a message on your answering machine/cell phone at work? Yes_____ No _____
  - May we leave a message with a family member? Yes _____ No _____
  - May we leave a message with a co-worker? Yes _____ No _____
  - May we discuss your medication(s)/condition(s) with any member of your family? Yes _____ No _____
- If YES, please name the members allowed:

NAME:_____/RELATIONSHIP: _____

This consent was signed by:

_____ _____
Printed patient name Date of Birth

_____ _____
Patient/ Parent or Guardian (if under 18) Signature Date

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Fax: 401-619-0623

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