Connecticut Foot Specialists, P.C.

Patient Name_____ Date of Birth _____/_____/_____
Last First MI

Address _____
Street City State Zip

Sex_____ Age _____ Home Phone _____ Cell Phone_____

Occupation _____Employer_____E-mail Address_____

Marital Status S_____ M_____ D _____ W _____ Spouse's Name _____

Primary Care Doctor_____
Name Address Phone

Relationship to Patient (please check one) _____Self _____ Parent _____Spouse _____ Other_____

Emergency Contact Name: _____Relationship:_____Phone:_____

Pharmacy Used: Name: _____Location:_____

How did you hear about our office? Internet Family Paper Friend Physician

If you were referred, please provide the following information about the referral source:

Name: _____ Address:_____ Phone_____

Internet (please specify): Google Yahoo Bing Yelp Other_____

MEDICAL HISTORY

Reason for your visit (please be specific):_____

Right Foot _____ Left Foot _____ Both Feet _____

Are your feet painful? Yes _____ No _____

How long has this been a problem? _____Work Related? Yes _____ No _____

What treatments have you tried?_____

Any past problems with your feet and/ or ankles?_____

Any past surgical procedures on your feet and/or ankles? _____

Shoe Size _____ Current Weight _____ Height _____ Have you worn orthotics? Yes No

GENERAL HEALTH HISTORY

Do you have diabetes? Yes _____ No _____ On Insulin? Yes _____ No _____

Have you had any serious illnesses? Yes _____ No _____ If yes, please explain:_____

_____

Have you had any major surgeries? Yes _____ No _____ If yes, what type : _____

Do you have an artificial joint(s)? Yes _____ No _____ If yes, location: _____

Do you have a Heart Valve Implant? Yes _____ No _____

Do you drink alcohol? Yes _____ No _____ If yes, how much: _____

Do you smoke? Yes _____ No _____ If yes, how many a day? _____ How many years? _____

Previously smoked? Yes _____ No _____ If yes, how many a day? _____ How many years? _____

Employment: Sit at work _____ Stand at work _____ Stand & walk at work _____ N/A _____

ALLERGIES (Please check off or note **any** allergies)

____Antibiotics (type) _____ ____ No Known Allergies

____ Aspirin ____Codeine ____Sulfa ____ Betadine (Iodine) ____Latex ____Penicillin ____Seafood

____Ibuprofen (Advil, Motrin) ____Local anesthetics (Novocaine, Lidocaine) ____ Other_____

MEDICATIONS (**please list below**, including non-prescription or herbal supplements) _____NONE (check if none)

_____

_____

Check any of the following that you have, or had a problem with:

____ Anemia	____ Diabetes	____ Lung Disease	____ Stomach Ulcers
____ Arthritis	____ Gout	____ Neurological Disorder	____ Thyroid Disorder
____ Asthma	____ Heart Disease	____ Phlebitis	____ Unexplained Weight Loss
____ Bladder	____ High Blood Pressure	____ Prolonged Breathing	____ Frequent Infections
____ Cancer	____ High Cholesterol	____Rheumatoid Arthritis	____ Other_____
____ COPD	____ Kidney Disease	____ Skin	____ None of the above

FAMILY HISTORY

Circle if any blood relatives have had: Arthritis Cancer Diabetes Heart Disease High Blood Pressure Kidney Disease

Any other pertinent information I should know? _____

Financial Policy for Connecticut Foot Specialists, P.C.

Thank you for choosing our office. We are committed to serving you with skilled and high quality care.

_____ (Initial) I give Connecticut Foot Specialists, P.C. permission to examine me and provide medical services. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

_____ (Initial) **CO-PAYS:** Are due at the time of service. Co-pays will not be billed.

_____ (Initial) **SELF PAY:** Payment is due in full at the time of service if you do not have health insurance.

_____ (Initial) **MEDICARE:** We are a participating Medicare provider. Medicare and your secondary insurance will be billed for you. You are responsible for your co-pay or any deductible amounts.

_____ (Initial) **SECONDARY INSURACE:** Your medical claim will be forwarded to your secondary insurance after payment and/or explanation is received from your primary insurance company.

_____ (Initial) **REFERRALS/AUTHORIZATIONS:** We are required to follow guidelines of your managed care plan with mandates that when you visit a specialist, you may need to have a referral from your primary care physician prior to seeking care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of visit. If a referral is not provided **you are** fully responsible for all services provided if denied by the insurance company.

_____ (Initial) High deductible plans will require a payment towards this deductible. The balance remaining will be billed to the patient.

_____ (Initial) **PATIENT BILLING:** I agree to pay Connecticut Foot Specialists, P.C. for any amount due after insurance payment has been made by my carrier and any contractual adjustments have been credited or the full amount of all bills incurred by me or the below named if there is no health coverage. You will be sent up to three notices for your financial responsibility. After the third and last notice, your account will be forwarded to collections and charged a 15% collection fee.

_____ (Initial) **ASSIGNMENT OF BENEFITS:** I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Connecticut Foot Specialists, P.C. all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non -covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care.

_____ (Initial) I understand that it is my responsibility to inform this office, immediately, if there are changes to my health insurance information. There may be an administrative fee for reprocessing insurance claims if information is not provided.

I authorize the use of the signature below on all insurance submissions. I have read the above policy regarding my financial responsibility to Connecticut Foot Specialists, P.C. for providing medical services to me or the below named patient. I agree to pay Connecticut Foot Specialists, P.C. for any amount due after insurance payment has been made by my carrier and any contractual adjustments have been credited or the full amount of all bills incurred by me or the below named if there is no health coverage.

Patient/ Financial Responsible Party Signature: _____ Date: _____

Physician Signature: _____ Date: _____

CONNECTICUT FOOT SPECIALISTS, P.C.

Summary of Notice of Privacy Practices

The notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosure of Health Information:

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures based on your Authorization:

Except as noted in more detail in the Notice of Privacy Practices, we will not use or disclose your health information, social security numbers of other financial information without your written consent.

Uses and Disclosures Not Requiring Your Authorization:

In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To government agencies for the purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To the law enforcement authorities to protect public safety or to assist in apprehending criminals;
- Where required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights:

As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate in confidence;
- To request that we amend your health information;
- To receive a notice of our privacy practices. A copy of the complete NOTICE is available upon request.

I acknowledge that I was provided a copy of the Notice of Privacy Policy from Connecticut Foot Specialists, PC and that I have read and understand the notice as mandated by HIPPA (Health Insurance Portability and Privacy Act).

Patient/ Financial Responsible Party Name: _____ Relationship: _____

Patient/ Financial Responsible Party Signature: _____ Date: _____