NEW ENGLAND FAMILY FOOT CARE

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Date of Appointment: _____

Patient Name: _____***If patient is a minor, please see last page and complete.**

Primary Care Physician: _____ **/ Date of Last PCP Visit:** _____

Sex: ☐ M ☐ F **Date of Birth:**_____ **Marital Status:** ☐ S ☐ M ☐ W ☐ D

Height: _____ft. _____ in. **Weight**_____lbs **Shoe Size**_____

COVID Vaccine: Date of 1st vaccination: _____ **2nd:** _____**3rd**_____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell:** _____ **Email:** _____

Confidential information to be sent via: ☐ Cell ☐ Home ☐ Email ☐ Letter/Mail

Emergency Contact: _____**Relationship to Patient**: _____

Emergency Contact Phone #: _____

Pharmacy Name & Address:_____

☐ Student ☐ Retired ☐ Employed/Employer: _____**Occupation:** _____

How did you hear about us? ☐ Friend/Family ☐ Internet/Google ☐ Insurance Company ☐ Facebook

☐ Advertisement ☐ Doctor Referral/Who? _____ **☐ Other**_____

General Health (check all that apply):

☐ Diabetes/A1c_____% ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Murmur ☐ Pacemaker
☐ Peripheral Neuropathy ☐ Stroke/Year_____ ☐ Blood Clot (DVT/PE) ☐ Poor Blood Flow/PVD ☐ Anemia
☐ Liver Disorder ☐ Stomach Ulcers ☐ Kidney Disorder ☐ Gastric Reflux/GERD ☐ Gout
☐ Osteoarthritis/Location_____ ☐ Anxiety ☐ Depression ☐ COPD
☐ Rheumatoid Arthritis/Location _____ ☐ HIV ☐ Genetic Disorder_____
☐ Cancer/Type_____ ☐ Heart Attack/Year _____
☐ Prosthetic/Joint Replacement (provide location) _____

Family History (please indicate the following: M-Mother, F-Father, G-Grandparent, S-Sibling):

☐ Diabetes____ ☐ Hypertension____ ☐ High Cholesterol ____ ☐ Heart Murmur ____
☐ Pacemaker____ ☐ Poor Blood Flow/PVD____ ☐ Blood Clot (DVT/PE)_____ ☐ Liver Disorder____
☐ Anemia____ ☐ Peripheral Neuropathy____ ☐ Gout____ ☐ Stomach Ulcers____
☐ Stroke____ ☐ Kidney Disorder____ ☐ Heart Disease____ ☐ Osteoarthritis____
☐ Rheumatoid Arthritis____ ☐ Cancer/Type_____ ☐ Genetic Disorder ____

Medications: _____

_____

Allergies: _____

Previous Surgeries & Date: _____

_____

Smoker: ☐ Y ☐ N **If yes, number of years:** _____ **Packs per day:** _____ **Drug use**: ☐ Y ☐ N

Reason For Visit: _____

Injury? ☐ Y ☐ N **Date of Injury:** _____

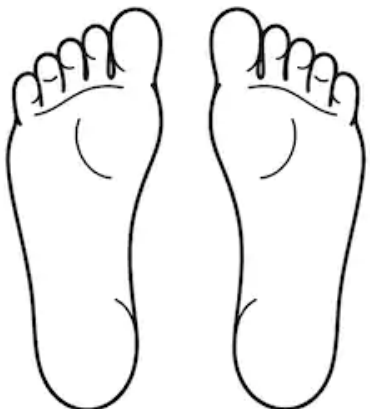
Duration of symptoms: _____

Pain level (circle one): 0 (no pain) 1 2 3 4 5 6 7 8 9 10

Previous treatment: ☐ Y ☐ N **If yes, please list any previous treatments:** _____

_____

Location of Problem <u>(please mark all areas that apply):</u>



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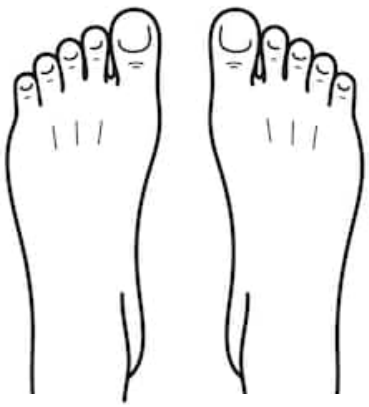

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Authorization:

Advanced Beneficiary Notice:

☐ Y ☐ N I hereby authorize payments directly to the physician of surgical and/or medical benefits.

☐ Y ☐ N I also understand I am responsible for any portion of my bill not covered by my insurance.

Release of Information:

☐ Y ☐ N I hereby authorize release of information for insurance claim purposes.

Print Name _____ **Signature** _____

Date _____

If accompanying a minor:

Guardian Name:_____ Relationship to patient:_____

Guardian cell phone number:_____ Guardian DOB:_____

Guardian Home Address: _____

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept debit cards, credit cards, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical and treatment procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due at the time of your visit.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- **Missed appointments and same day cancelation of an appointment will be subject to a fee of $50.00**. Your insurance company does not cover this fee.
- Repeated missed appointments, same-day cancellations, and/or tardiness is subject termination of services.

By signing below, I understand and agree to the above statements.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____