OXBURY FOOT & ANKLE CENTER

PATIENT INFORMATION

DATE: _____

REFERRED BY: _____

PATIENT NAME: _____

GENDER: ____ FEMALE ____ MALE

SSN#_____ DOB: _____ AGE: ____

MARITAL STATUS

___ Single ___ Married ___ Separated ___ Widowed ___ Divorced

ADDRESS: _____

TOWN: _____

STATE: _____ ZIP CODE: _____

PHONE NUMBERS & E-MAIL

Home # _____ Cell # _____

E-MAIL ADDRESS: _____

OCCUPATION: _____

STUDENT: ___ YES (**___ FT ___ PT)** ___ NO

EMPLOYER: _____

EMPLOYER PHONE # _____

EMPLOYER ADDRESS: _____

TOWN/STATE/ZIP: _____

SPOUSE OR PARENT NAME: _____

SPOUSE OR PARENT ADDRESS: _____

TOWN/STATE/ZIP: _____

SPOUSE/PARENT OCCUPATION: _____

SPOUSE/PARENT EMPLOYER: _____

*****Emergency Contact*****

Name: _____

Address: _____

Town/State/Zip: _____

Relationship to Patient: _____

Home # _____ Cell # _____

INSURANCE

PRIMARY INSURANCE

Subscriber Name: _____
Subscriber SSN # _____ DOB: _____
Insurance Name: _____
Insurance ID# _____
Insurance Phone # _____
Patient's Relationship to Insured
____ Self ____ Spouse ____ Child ____ Other

SECONDARY INSURANCE

Subscriber Name: _____
Subscriber SSN # _____ DOB: _____
Insurance Name: _____
Insurance ID# _____
Insurance Phone # _____
Patient's Relationship to Insured
____ Self ____ Spouse ____ Child ____ Other

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I or my dependent has insurance coverage as indicated above and assign directly to Doctor **Chieppa or Pizzano.** All insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits.
I authorize the use of this signature on all insurance submissions.

_____ _____
Print Name **Relationship**

_____ _____
Signature of Patient, Parent or Guardian **Date**

MEDICARE AUTHORIZATION

I request that payment of authorize Medicare benefits to be made either to me or on my behalf to Doctor **Chieppa or Pizzano** for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my Signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and no covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____
BENEFICIARY PRINT NAME

_____ _____
SIGNARURE **DATE**

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated?
(Please include foot, ankle, knee, thigh and hip complaints)

_____

Have you ever been to a Podiatrist before? ___ Yes ___ NO
If Yes, Name & Phone # of Doctor: _____ Last Visit? _____

Is there any personal or family **HISTORY OF DIABETES**? ____Yes ____ NO
Cigarette/Tobacco Use (Years Smoked ___) ____ Yes ____NO
ATHLETIC ACTIVITIES in which you participate (LIST & INCLUDE FREQUENCY)
1) _____
2) _____
3) _____

Please indicate which foot problems you now have or have had in the past:

ANKLE PAIN	__Yes	__NO
ATHLETE'S FOOT	__Yes	__NO
BUNIONS	__Yes	__NO
CORNS & CALLOUSES	__Yes	__NO
CRAMPS IN FEET OR LEGS	__Yes	__NO
FLAT FEET	__Yes	__NO
HEEL PAIN	__Yes	__NO
INGROWN TOENAILS	__Yes	__NO
NUMBNESS IN FEET OR LEGS	__Yes	__NO
PLANTAR'S WARTS	__Yes	__NO
SWELLING IN ANKLES OR FEET	__Yes	__NO

MEDICAL HISTORY

Place a mark on Yes or NO to indicate if you have had any of the following:

AIDS/HIV	_Yes _NO	Ear Problems	_Yes _NO	Rash	_Yes _NO
Allergies to Anesthetics	_Yes _NO	Epilepsy	_Yes _NO	Respiratory Disease	_Yes _NO
Allergies to Medicine or Drugs	_Yes _NO	Eye Problems	_Yes _NO	Rheumatic Fever	_Yes _NO
Anemia	_Yes _NO	Fainting	_Yes _NO	Shortness of Breath	_Yes _NO
Angina	_Yes _NO	Gout	_Yes _NO	Sinus Problems	_Yes _NO
Arthritis	_Yes _NO	Headaches	_Yes _NO	Special Diet	_Yes _NO
Artificial Heart Valves or Joints	_Yes _NO	Heart Disease	_Yes _NO	Stroke	_Yes _NO
Asthma	_Yes _NO	Hemophilia	_Yes _NO	Swollen Neck Gland	_Yes _NO
Back Problems	_Yes _NO	Hepatitis or Jaundice	_Yes _NO	Thyroid (Hyper or Hypo)	_Yes _NO
Bleeding Disorders	_Yes _NO	High Blood Pressure	_Yes _NO	Tuberculosis	_Yes _NO
Cancer (Type _____)	_Yes _NO	High Cholesterol	_Yes _NO	Ulcers	_Yes _NO
Chemical Dependency	_Yes _NO	Kidney Problems	_Yes _NO	Varicose Veins	_Yes _NO
Chest Pain	_Yes _NO	Liver Disease	_Yes _NO	Venereal Disease	_Yes _NO
Chronic Diarrhea	_Yes _NO	Low Blood Pressure	_Yes _NO	Weight Loss Unexplained	_Yes _NO
Circulatory Problems	_Yes _NO	Nervous Problems	_Yes _NO		
DIABETES	_Yes _NO	Radiation Treatment	_Yes _NO		

OTHER NOT LISTED: _____

SURGERIES
(you have had)

_____ _____
_____ _____
_____ _____
_____ _____

Hospitalization
(Other than for surgeries)

_____ _____
_____ _____
_____ _____

FAMILY PHYSICIAN:
Name: _____ **Date of Last Visit:** _____
Address: _____ **Physician Phone #** _____

Are you now or have you been under any other doctor's care for any reason over the past two years? _____ Yes _____NO
If yes, please explain: _____
Name of Doctor & Phone # _____

MEDICATIONS

Include all prescriptions, over-the-counter medications *and* vitamins

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

***Pharmacy Name*:** _____
Pharmacy Phone # _____ _____

MEDICATION ALLERGIES

				Other Allergies:
___Adhesive/Tape	___Codeine	___Latex	___Penicillin	_____
___Anticoagulant Therapy	___Demerol	___Local Anesthetics	___Seafood	_____
___Aspirin	___Iodine	___Novocain	___Sulfa	_____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to Administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

_____ _____ _____
Date **Printed Name of Patient** **Signature of Patient, Parent or Guardian**

ROXBURY FOOT & ANKLE CENTER, PA
FINANCIAL POLICY

We are pleased that you have choses us as your podiatric care provider. We are committed to your treatment being successful and are certain you will be happy with the care provided by our staff. The following is a statement of our Financial Policy which we ask you to read and sign prior to any treatment.

ALL patients must complete our Patient Information Forms before being examined by the Doctor.

REGARDING INSURANCE

As a convenience to our patients, we submit claims to your insurance company on your behalf. We CANNOT bill your insurance company **UNLESS** you bring in **ALL** your insurance information (this includes insurance cards and referrals). Patients who are in an **HMO** program *MUST PRESENT A REFERRAL PRIOR TO BEING SEEN BY THE DOCTOR*. Patients that have a **POS** plan can be seen without a referral; however, the expense will be applied to your deductible. Failure to do so will result in rescheduling the appointment. If you do not have a referral and you choose to be seen by the doctor, payment in full for services rendered will be required at the time of visit.

We require that all copays, deductibles, and services not covered by your insurance be paid at the time of service. (This includes in office supplies such as pads, nail pack etc.).

Your insurance policy is a contract between you and your insurance company. In the event that your insurance company has not paid your account within 45 days, the responsibility to pay the balance will automatically be transferred to you. Please be aware that some or all services provided by the doctor may not be covered and not considered reasonable or necessary under the Medicare Program and/or other insurance plans. Any non-covered services or amounts not paid by your insurance company are due within 30 days of the billing date. An interest rate of **1 ½ %** per month will be added to the unpaid balance of your bill that is 60 days or more overdue.

Again we are billing your insurance company as a convenience to you. The insurance industry is changing every day and we will make every effort to assist you, however, it is the patient's responsibility to know and be aware of his/her own plan coverage, deductibles, copays and limitations. If your insurance should change or if any information pertaining to yourself, your employer, and/or your dependents, please notify us as soon as possible to avoid any delays in processing information.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You may be responsible for payments that your insurance company considers to be above the "*usual and customary rate*."

MISSED APPOINTMENTS

Please help us serve you better by keeping your scheduled appointments. If you are unable to keep an appointment, we require that you notify the office at least 24 hours in advance to avoid a cancellation fee.

Thank you for reviewing our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy and authorize Roxbury Foot and Ankle Center, PA to apply for benefits on my behalf for services rendered by Dr. Chieppa and Associates. I request payment to be made directly to Roxbury Foot & Ankle Center, PA. I certify the information given is correct and true to the best of my ability. I further authorize the release of necessary information, including medical information for this or any other related claim to my insurance company. I permit copy of authorization to be used in place of the original. I hereby give permission to Dr. Chieppa and Associates to examine and treat my feet and ankles as needed. I understand and acknowledge this statement.

_____	_____
Print Name of Patient	Signature of Patient, Parent or Guardian
_____	_____
Date of Birth	Date

PRIVACY PRACTICES ACKOWLEDGMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____	_____
Print Name of Patient	Signature of Patient, Parent or Guardian
_____	_____
Date of Birth	Date