OXBURY FOOT & ANKLE CENTER

Please complete this forms in order to ensure proper billing of your services. **Please Print**

Today's Date: _____

PATIENT INFORMATION

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

PATIENT NAME: _____ DATE OF BIRTH: _____

AGE: _____ GENDER: FEMALE _____ MALE _____ SOCIAL SECURITY NUMBER: _____

MARITAL STATUS: Single _____ Married _____ Separated _____ Widowed _____ Divorced _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____ Preferred Method of Contact:: _____

E-MAIL ADDRESS: _____ Preferred Language: English ___ Spanish ___ Other: _____

Employment Status: Full Time ____ Part Time ____ Self Employed ____ Retired ____ Disabled ____ Student ____ Other: _____

EMPLOYER NAME: _____ EMPLOYER ADDRESS: _____

CITY/STATE/ZIP: _____ WORK PHONE: _____

EMERGENCY CONTACT NAME: _____ Relationship to Patient:: _____

HOME PHONE: _____ CELL PHONE: _____ Preferred Method of Contact: _____

INSURANCE INFORMATION

PRIMARY CARRIER: _____ Insurance ID# _____

ADDRESS: _____ Insurance Phone # _____

Subscriber Name: _____ Subscriber SSN # _____ DOB: _____ Gender: Female ___ Male ___

Relationship to patient: Self ____ Spouse ____ Child ____ Other ____

SECONDARY CARRIER: _____ Insurance ID# _____

ADDRESS: _____ Insurance Phone # _____

Subscriber Name: _____ Subscriber SSN # _____ DOB: _____ Gender: Female ___Male ___

Relationship to patient: Self ____ Spouse ____ Child ____ Other ____

GUARANTOR INFORMATION

Please complete if guarantor is other than self. (Guarantor is the person financially responsible for this bill.)

GUARANTOR : _____ Patient's Relationship to Guarantor: _____

SOCIAL SECURITY # _____ DOB: _____ Gender: Female _____ Male _____

ADDRESS: _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE: _____ CELL PHONE: _____ Preferred Method of Contact: _____

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	**Other Not Listed**: _____		
DIABETES	_Yes	_NO	Radiation Treatment	_Yes	_NO	_____		
						_____		

MEDICATION ALLERGIES

___Adhesive/Tape	___Codeine	___Latex	___Penicillin	___ Not Known Drug Allergies
___Anticoagulant Therapy	___Demerol	___Local Anesthetics	___Seafood	___ **Other Allergies Not listed**: _____
Aspirin	Iodine	Novocain	Sulfa	

SURGERIES _____ _____
(you have had) _____

Hospitalizations _____
(Other than for surgeries) _____

MEDICATIONS (Include all prescriptions, over the counter medications and vitamins)

_____
_____
_____
_____
_____

PHARMACY NAME & TOWN: _____ **PHONE NUMBER:** _____

Primary Care Physician: _____ **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, explain: _____
_____

Name of Doctor: _____ Phone Number: _____

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.

Printed Name of Patient: _____ Relationship:_____

Signature of Patient, Parent or Legal Guardian: _____ Date: _____

MEDICARE AUTHORIZATION (Only for patients with Medicare plans)

I request that payment of authorizes 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

Printed Name of Patient: _____ ___ Relationship:_____

Signature of Patient, Parent or Legal Guardian: _____ Date: _____

Disclosures to Authorized Individuals

I understand that RFAC may release my Protected Health Information (PHI) to family member, friend, or other person I indicate is involved in my care unless I object. I designate the following person(s) listed as a person or persons involved with my health care and/or payment for my health care.

Name: _____ Relationship: _____

Address: _____

Phone Number: _____ Health Info ___ Yes ___ No Payment Info __ Yes __ No

CONSENT

I certify that all the information provided 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.

Printed Name of Patient: _____ ___ Relationship:_____

Signature of Patient, Parent or Legal Guardian: _____ Date: _____

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*."

MEDICAL APPOINTMENT CANCELLATION POLICY

We strive to provide excellent medical care to you, your family and all of our patients. In order to do so effectively and efficiently, we have developed an appointment system that sets asides ample time for a patient. "No-shows", and late cancellations inconvenience those individuals who need access to medical care in a timely manner. In an effort to reduce the number of such occurrences, we have implemented a Medical Appointment Cancellation Policy and it is effective immediately. Our policy is as follows:

We request you give our office a **24 hour notice** in the event you need to reschedule your appointment. Our phone number is 973-927-2525. If you miss an appointment and do not contact us with at least a 24 hour prior notice, we will consider this a missed appointment and a **$30.00 no-show fee** will be assessed to you. This applies to late cancellations and "no-shows." Our office makes reminder calls for appointments. It is ultimately the patient's responsibility to remember their scheduled appointments. This fee will be billed to you directly and is **not covered** by your insurance. This balance must be paid prior to your next appointment. If you don't have a scheduled appointment, the balance is expected in a timely fashion and if not, will be subject to collections.

Thank you for reviewing our Financial Policy & Medical Appointment cancellation policy. Please let us know if you have any questions or concerns.

I have read the Financial and medical appointment cancellation policy and agree to the terms of this policy. I also 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.

Printed Name of Patient	Signature of Patient, Parent or Legal Guardian	Date

ROXBURY

FOOT AND ANKLE CENTER

THE DOCTORS' CHOICE FOR FOOT CARE

The Health Insurance Portability and Accountability Act

HIPAA Acknowledgement

Notice of Privacy Practices

Printed Name of Patient: _____

Patient Date of Birth: _____

I acknowledge receipt of RFAC Notice of Privacy Practices.

Signature of Patient, Parent or Legal Guardian: _____

Date: _____