Lower Westchester FOOT & ANKLE PODIATRY, SURGERY SPORTS MEDICINE

INITIAL VISIT PATIENT INFORMATION FORM

First Name ______________________________ MI _____ Date of Birth _______________

Last Name ________________________________________

**Demographic Information:** Gender: M F Home# ______________________

Email:_________________________________________ Mobile # ________________________

How would you like reminders? Phone Text E-mail Work # ________________________

Preferred Language: _________________ Ethnicity: ___________________ Race:__________________________

**Home / Mailing Address**

Address _______________________________________________________ Apt # ________

City _____________________________ State ___________________ Zip Code__________

**Providers:** Your Primary Care Doctor_________________________ Phone # ____________________

Your Local Pharmacy ____________________ Address/City/Town________________________________________

If insurance is in someone else's name – please provide:Full name______________________ DOB ______________

**Insurance Carrier:** _________________________________ **Policy ID#** _____________________________________

**Responsible Party:** Name: _____________________________ Relation: ________________Phone number: ________________

**Emergency Contact:** Name: ____________________________ Relation: ________________Phone number:________________

Whom may we thank for referring you to our office? _______________________________

---

Do not leave anything blank. Please enter **"NONE"** If negative.

Weight ____________ lbs Height ________________ Shoe Size: _______________

**MEDICAL HISTORY:** ☐Diabetes Stroke Neuropathy Cancer (chemo) Arthritis Thyroid Gout Hypertension

**What are your medical conditions?** (past and present): _____None ______________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

**List All Surgeries with Date**: _____None ____________________________________________________________

____________________________________________________________________________________________

**FAMILY HISTORY:** List family members with bone/joint problems (Similar to your problem?): _____None _______________

____________________________________________________________________________________________

**SOCIAL HISTORY:** _________________________________________________________________________

Substances –Tobacco Y____ N____ (Packs ____ years _____) Alcohol (type & quantity _________________)

What kind of **work** do you do? __________________________________________ Drugs? ______________________________

**List All Hospitalization / Procedures / Injuries with Date** (Sprains/Fractures): _____None __________________________

____________________________________________________________________________________________

**List All Medications, Pills**: _____None ______________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

**List All Allergies**: _____None __________________________________________________________________

**IMAGING:** Have you had previous MRI for this problem? Y ______ N______ (date and study results) _______________________

____________________________________________________________________________________________

Lower Westchester FOOT & ANKLE
PODIATRY,SURGERY SPORTS MEDICINE

I acknowledge that a copy of HIPAA privacy policy and the Payment Policy has been made available to me. In addition to standard HIPAA privacy regulation, our policy regarding privacy is very simple. We don't share or sell or provide any information about any patient for any reason other than the course of required medical care and coordination with your other providers; or insurance regulation and authorization; or in concurrence with required health and safety regulation.

**This is your assignment of medical benefits**

I request that payment of authorized Medicare and other insurance benefits be made for any services provided to me. I understand my signature request be made and authorizes the release of medical information necessary to pay the claim. I know that I will be financially responsible to pay all deductibles, coinsurance or co-payments at time of visit. My signature authorizes the doctor to release all information necessary to secure the payment of benefits. I authorize my signature below for any an all future submissions.

X__________________________________________ DATE ______________________________

Signature of Patient

## Payment Policy

Thank you for choosing us as your podiatrists. We are committed to providing you with quality and affordable health care. Our practice provides a premium, no rush medical service. We pride ourselves for timeliness of appointment, 4 patients per hour, and no 6 minute medicine. All of our patients get the time and attention they deserve; including detailed explanation and treatment. This payment policy agreement is aimed at answering your questions regarding patient and insurance responsibility for services.

1. **Insurance**. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance with any questions regarding your coverage. Many plans have restricted coverage for routine nail, corns and callouses, in this case, you are responsible for the uncovered portion.
2. **Co-payments and deductibles**. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

**Remaining or high deductibles**: Services fees applied to deductibles are collected at time of visit. Charges are calculated per Medicare fee schedule at 20% discount. This generally assures that additional balance will be due, as opposed to overpayment. Collected deductible charges are not intended to be final charges, nor reflect final actual fee. Final fees are calculated by your insurance company, and are billed for balances after insurance approval or denial.

3. **Non-covered services**. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered necessary by your insurer. You must pay for these services in full at the time of visit. Many plans have restricted coverage for routine nail, corns and callouses, if this is the case, you are responsible for the uncovered portion, regardless of the insurance plan. You may be asked to sign additional agreements at each of your appointments for services that may be denied by your plan. These agreements are acknowledgments that you are responsible for the uncovered portion.
4. **Proof of insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information, you may be responsible for the balance of a claim.
5. **Claims submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If the insurance company does not pay your claim in 45 days, the balance is billed to you.
7. **Nonpayment**. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
8. **Missed appointments**. The only way to avoid rushed appointments, double booking, and limit to 4 patients per hour; is if all patients keep their appointments. Our policy is to charge $65 for missed appointments not canceled within 24 hours. These charges are your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
9. **Additional charges**. Completion of forms, record copies, reviews and summaries are self pay fees regardless of insurance carrier.
10. **Non guarantee**: There is no guarantee for results of medical services or procedures provided.

Our practice is committed to providing the best treatment to our patients.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.
**I have read and understand the payment policy and agree to abide by its guidelines:**

X__________________________________________ DATE ______________________________

**Signature of Patient**