Lower Westchester FOOT & ANKLE PODIATRY, SURGERY SPORTS MEDICINE

Ari Rubinstein, DPM & Bryan B. Kagan, DPM

INITIAL VISIT PATIENT INFORMATION FORM

First Name _____ MI _____ Today's Date _____/____/_____

Last Name _____ Date of Birth ____/____/_____

Gender: M F (circle one)

Email:_____@_____ Home# (_____) - _____-_____

How would you like reminders? Phone Text E-mail Mobile # (_____) - _____-_____

Demographic Information: Work # (_____) - _____-_____

Preferred Language: _____ Ethnicity: _____ Race:_____

Home / Mailing Address

Address _____ Apt # _____

City _____ State _____ Zip Code_____

Pharmacy:

Your Local Pharmacy _____ Address/City/Town_____

Your Primary Care Doctor_____ Phone # (_____) - _____-_____

If insurance is in someone else's name – please provide:

Full name_____ Relationship _____ DOB __/___/___

Responsible Party:

Name: _____ Relation: _____ Phone number: _____

Emergency Contact:

Name: _____ Relation: _____ Phone number: _____

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

LEGAL: IS THERE A LEGAL CASE PENDING? Y___ N___ NAME OF LAWYER _____

I acknowledge that a copy of HIPAA privacy policy and the Payment Policy has been made available to me.

This is your assignment of medical benefits

MEDICARE

I request that payment of authorized Medicare benefits be made to Dr. Kagan or Dr Rubinstein 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. I authorize my signature below for any an all future submissions. I understand my copay is due at time of service.

ALL OTHER INSURANCES

I request that payment of authorized medical benefits be made to Dr. Kagan or Dr Rubinstein and that I will be financially responsible for all deductibles, coinsurances and stated 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 all future submissions.

X_____ DATE _____

Signature of Patient

We accept cash and checks only. Sorry no credit or debit cards

Please complete both sides of this form

Lower Westchester FOOT & ANKLE
PODIATRY, SURGERY SPORTS MEDICINE

Payment Policy **Patient Name_____**

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 complete explanation of medical condition, course of disease and treatment. Some of our patients have had questions regarding patient and insurance responsibility for services, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

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 company with any questions you may have regarding your coverage. Some plans have restricted coverage for routine nail, corns and callouses, if this is the 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. In the event of overpayment, refunds are made on a monthly basis.
3. **Non-covered services**. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurer. You must pay for these services in full at the time of visit. Some 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 acknowledgements that you are responsible for the uncovered portion, fees are collected at the time of visit.
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 certain 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 claim. 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 your insurance company does not pay your claim in 45 days, the balance will automatically be 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 we can continue to provide no rush appointments, no double booking, and limit appointments 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, a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment. Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges the area.

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 _____

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PLEASE COMPLETE ENTIRE FORM. DO NOT LEAVE ANYTHING BLANK.

Name: _____

Why are you here today? (Please be specific) _____

_____

_____

REVIEW OF SYMPTOMS: PLEASE CIRCLE ANY THAT YOU ARE EXPERIENCING TODAY

Constitutional	Fever	Chills	Nausea	Weight Loss	Night Sweats	Vomiting
Cardiovascular	Chest pain	Shortness of Breath	Leg/Night Cramps	Cold Extremity	Swelling	
Gastrointestinal	nausea	Vomiting	Gas	Stool change	Blood	
Musculoskeletal	Swelling	Weakness	Stiffness	Twitch	Fatigue	
Skin	Rash	lesion	Mole	Lump	Scar	Color change
Endocrine	Thirst	Overeating	Fatigue	Feeling hot / Cold	Growth/ hair problem	
Neurological	Weak	Numb	Balance	tingling	Coordination	
Hematological	Bruising	Bleeding	Anemia	Nodules		

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

Height _____ ft _____ in Weight _____ lbs

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

What are your medical conditions? (past and present): _____

_____

_____

List All Surgeries with Date: _____

_____

FAMILY HISTORY:

List family members with bone/joint problems (Similar to your problem?): _____

_____

SOCIAL HISTORY:

S / M / DP / W / D Live Alone / With Family or Someone Pvt house /Apt/ Elevator / Stairs / What floor? _____

Substances -Tobacco (Packs ___ years ___) Alcohol (type & quantity _____) Drugs? _____

What kind of **work** do you do? _____ Currently Working? Y___ N___

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

_____

_____

List All Medications, Pills: _____

_____

_____

List All Allergies: _____

IMAGING: Have you had previous X-ray, CAT scan, MRI for this problem? Y ___ N___ (please give date and study results)

_____

_____