

MICHAEL J. FRANK, D.P.M., MARC GOLDBERG, D.P.M., ADAM LOWY, D.P.M.

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PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer / School _____

Employer / School Address _____

Employer / School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouses Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Drs. Michael Frank, Marc Goldberg, and Adam Lowy 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE /MEDI GAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Drs. Frank, Goldberg, and Lowy for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits for benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative

Please print name of Beneficiary, Guardian or Personal Representative

Date

Relationship to Beneficiary

PODIATRIC HISTORY

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

Is there any personal or family history of diabetes?

Yes No

Your Occupation _____

Cigarette/ Tobacco use _____

Years smoked _____

Athletic activities in which you participate (please list and indicate frequency)

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 and Calluses Yes No

Cramps or Numbness in Feet/Legs Yes No

Flat Feet Yes No

Foot or Leg Cramps Yes No

Heel Pain Yes No

Ingrown Toenails Yes No

Plantar Warts Yes No

Swelling in Ankles or Feet Yes No

Tired Feet Yes No

Have you ever been to a Podiatrist before?

Yes No

If Yes, please list:

Name _____

Last Visit _____

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

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Medicine or Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foot or Leg Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves or Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling in Ankles, Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis or Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tired Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neuropathy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, Unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Ear Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Surgeries you have had: _____

Hospitalization other than for the surgeries listed: _____

Family Physician _____ Last Visit Date: _____

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: _____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

Pharmacy _____

Pharmacy Phone (____) _____

Do you take oral contraceptives? Yes No

ALLERGIES

- | | |
|------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Adhesive/ Tape | <input type="checkbox"/> Ibuprofen |
| <input type="checkbox"/> Anticoagulant Therapy | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Seafoods |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Latex |

Other _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Signature of Patient, Guardian or Personal Representative

Date

Please print name of Patient, Guardian or Personal Representative

Relationship to Patient

FINANCIAL POLICY FOR FAMILY FOOT AND ANKLE ASSOCIATES OF MARYLAND, P.A.

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not 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.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service if there is no secondary insurance.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES: All co-payments and deductible 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.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

24 HOUR CANCELLATION POLICY: I understand that Family Foot & Ankle Associates of Maryland, P.A. will bill me for appointments missed or not canceled with at least 24 hours notice.

CLAIM 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.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA, Mastercard, and Discover. An additional \$35.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* to Family Foot & Ankle Associates of Maryland, P.A. for medical services provided. I agree to pay Family Foot & Ankle Associates of Maryland, P.A. any balance unpaid by my insurance carrier for myself or the below named person.

ASSIGNMENT OF BENEFITS: I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Family Foot & Ankle Associates of Maryland, P.A.** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize **RELEASE OF MEDICAL INFORMATION** to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

PRINT Patient Name: _____

Signature: _____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: _____

Signature: _____

Relationship to Patient: _____ Date: _____

**PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION
DISCLOSURE FORM**

FAMILY FOOT & ANKLE ASSOCIATES OF MARYLAND, P.A.

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice of Privacy Practices and agree to its terms.

Patients Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature

II. Acceptable Means of Communications:

I give Family Foot & Ankle Associates of Maryland, P.A. permission for the doctor's and/or staff to leave messages for me at home, work, or cell phone as needed regarding appointments, billing, or any other information regarded as necessary.

Exclusion: () NONE or _____

Signature

Date