WELCOME TO OUR OFFICE: Joseph M. Toole DPM Daniel J. Saporito DPM Joseph F. Daley DPM

Today's Date_____

Last Name_____First_____Middle Int.____Date of Birth_____
Address_____City_____Zip Code_____
Home ( ) _____Work ( ) _____Cell ( ) _____
Social Security#_____ Sex_____Occupation_____
Email Address: _____
Employer_____Address_____
Marital Status: _____ Name of Spouse/Parent_____
Emergency Contact Person:_____Relation_____Their Phone( )_____
Race/Ethnicity: ___Caucasian (White) ___African-American ___Pacific Islander ___Hispanic ___Asian ___Other
___Refused Primary Language_____
Whom may we thank for referring you to our office? _____
Primary Care Physician Name: _____Specialist:_____
Current Medications (or you can supply a list) _____
_____

Allergies: ___Penicillin ___Sulfa Drugs ___Codeine ___Xylocaine ___Aspirin ___Motrin ___Adhesive Tape
___Betadine ___Latex Others_____ ___No Allergies

Pharmacy: Name:_____Address:_____City:_____

Medical History (Please check):

__Heart Attack	__Hiv/Aids	__Respiratory Disorders
__Alzheimer's/Dementia	__Hypertension	__Asthma ___Hepatitis/Liver Disorder
__High Cholesterol (Hyperlipidemia)	__Peripheral Neuropathy	__Sleep Apnea __Use CPAP Machine
__Mitral Valve Prolapse	__Arthritis	__Seizure Disorder __Stroke
__Cancer (_____)	__Osteoporosis	__Kidney Disorder __Kidney Stones
__Coronary Artery Disease	__Gout	__Thyroid Disorder
__Diabetes	__Chronic Foot Problems	__Raynauds __Depression/Anxiety

__I HAVE NO MEDICAL CONDITIONS AND THEREFORE TAKE NO MEDICATIONS
_____

Social History: Do you drink alcohol? __Yes, every day __Yes, socially __No, rarely
Do you smoke? __Yes, every day __Yes, sometimes
__Former smoker, I quit_____years ago ___Never smoked
Any illicit drug use? __Yes __No if yes, please explain_____
Are you pregnant? __Yes __No
Do you exercise regularly? __Yes __No

Surgical History (Please Check):

__Adverse Reaction to Anesthesia	__Appendectomy	__Foot Surgery	__Thyroid Surgery
__Cesarean Section (___)	__Gall Bladder Removal	__Knee Surgery	__Lung Surgery
__Hysterectomy	__Colonoscopy	__Colon Surgery	__Hip Surgery __Tonsillectomy
__Tubal Ligation __Hernia Repair	__Back Surgery	__Neck Surgery	__Adenoid Removal
__Prostate Surgery Biopsy of (_____)	__Shoulder Surgery	Metal/Implants placed during_____surgery	
__Heart Surgery __Heart Valve Replacement	__Pacemaker	__Cath Stent Placement	__CABG

_____

Family History (Please check boxes): __No significant family history/unknown
Indicate M for Mother, F for Father, B for Brother, S for Sister

____Alcoholism	____Diabetes	____Liver Disease	____Thyroid Disease
____Alzheimers	____Glaucoma	____Lung Disease	____Kidney Disease
____Anxiety	____Heart Attack	____Mental Disorders	____Foot Problems
____Asthma	____Heart Disease	____Migraine/Headaches	____Hiv/Aids
____Bleeding problems	____Seizure Disorders	____Stroke	____Cancer (_____)
____Arthritis			

Register_____ EHR_____

Wyoming Valley Foot Associates, P.C.

Joseph M. Toole DPM Daniel Saporito DPM Joseph F. Daley DPM

_____ _____

Patient Name Date

Initial Podiatric History

1) What is your main problem today? _____

_____

2) How long have you had this problem? _____

_____

3) When did your problem begin? _____

_____

4) Was this due to an injury? _____ If yes, was this a work injury? _____ Auto accident?_____
Please describe injury_____

5) How would you describe the pain? Burning, throbbing, dull, aching, other?
_____

6) What makes the problem worse? _____

7) What makes the problem better? _____

8) Are there any other associated signs or symptoms?_____

9) Have you been treated by any other physician or podiatrist for this problem?_____
If yes, who did you see?_____

10) Do you have any other foot problems that you've noticed?_____

_____

11) Have you had previous foot surgery? If so, please describe_____

_____Date of surgery_____

_____Surgeon's Name: _____

Consent for Treatment: 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 and may be deemed necessary in the diagnosis and/or treatment of my feet, ankles or lower legs. I hereby authorize medical information to be sent to my primary physician.

Signature_____ Date_____

Continuation of Medical History: Patients: Name_____

Review of Systems: Please indicate any **PERSONAL** history below (Check the box if it relates to you)

Podiatric Symptoms:

Joint pain ____
Joint stiffness/swelling ____
Weakness of muscles ____
Muscle pain or cramps ____
Cold Feet/legs ____
Difficulty walking ____
Swelling of the feet/ankles ____

Genitourinary:

Kidney Stones ____
Kidney dialysis ____

Cardiovascular:

Chest pain ____
Palpitation ____
Shortness of breath ____

Respiratory:

Chronic or frequent coughs ____
Spitting up blood ____
Shortness of breath ____
Wheezing ____

Gastrointestinal:

Loss of appetite ____
Nausea or vomiting ____
Abdominal pain ____

Hematologic/Lymphatic:

Slow to heal after cuts ____
Bleeding or bruising ____
Anemia ____

Overall Symtoms:

Good general health lately ____
Recent weight change ____
Fever ____
Fatigure ____

Integumentary (skin):

Rash or itching ____
Change in skin color ____
Change in nails ____
Varicose veins ____

Endocrine:

Skin becoming dryer ____
Excessive thirst/urine ____
Heat/cold intolerance ____

Neurological:

Frequent/recurring headaches ____
Light headed or dizzy ____
Convulsions or seizures ____
Numbness/tingling ____
Tremors ____
Paralysis ____

Psychiatric:

Memory loss or confusion ____
Nervousness ____
Depression ____
Insomnia ____

Pneumonia Vaccine Yes_____
No_____

Medical History Statement:
To the best of my knowledge, the questions on my patient information/history form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my medical history including but not limited to allergies, past medical history, etc.

Sign_____ Date_____

Wyoming Valley Foot Associates, P.C.

Insurance Authorization Form

Patient Name_____

1. **Medicare**- I request that payment of authorized Medicare benefits be made on my behalf to Wyoming Valley Foot Associates, P.C. for services furnished to me. I authorize any holder of medical information about me to release to the Centers For Medicare/Medicaid services and its services. I understand my signature requests that payment be made and authorized 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, my signature authorizes releasing the information to the insurer or agency shown. Wyoming Valley Foot Associates, P.C. accepts the charge determination of the Medicare carrier as the full charge and I am responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

2. **Medigap/Secondary Insurance**- I understand that if a medigap policy or other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request the payment of authorized secondary insurance benefits be made on my behalf to Wyoming Valley Foot Associates, P.C., if possible or otherwise to me.

3. **Assignment of Private/Commercial Insurance Benefits**- I hereby assign Wyoming Valley Foot Associates, P.C. and authorize and direct that payment be made directly to Wyoming Valley Foot Associates, P.C. of all benefits otherwise payable to me under the terms of my insurance policies(including major medical policies) by reason of the services described in the statements rendered by Wyoming Valley Foot Associates, P.C. provided that Wyoming Valley Foot Associates, P.C. shall refund the person(s) entitled to receive the same if any payments in excess of its full regular charges. I understand that I am financially responsible for all changes not covered by the assignment.

Patient Insurance Information

Primary Insurance:_____
Subscriber_____ Birthday of Subscriber_____
Relationship to Patient: __Self __Spouse __Child
Secondary Insurance:_____
Subscriber_____Birthday of Subscriber_____
Relationship to Patient: __Self __Spouse __Child

The above information is correct to the best of my knowledge. I understand that throughout my treatment at Wyoming Valley Foot Associates, P.C., I am responsible for notifying the practice of any and all updates to the information listed above.

_____

Signature of the Patient or Authorized Guardian Date

Wyoming Valley Foot Associates, P.C.

Financial Policy

We welcome you as our patient and thank you for choosing us as your foot and ankle healthcare provider. We believe that establishing a written financial policy is mutually beneficial to all parties involved. It is our goal to avoid any misunderstanding or concerns regarding financial matters in order to focus our energies on providing excellent health care.

The following are our rules/policies relative to patient financial responsibility:

1) Payment is required at the time services are rendered. This includes co-pays, deductibles, and co-insurance as well as payment for non-covered services and supplies. Failure to pay copay at the of visit will incur $5 billing fee. Further you will be responsible for any medical services deemed "non-covered," "coverage terminated," "pre-existing" or a "non-covered member" by your insurance. We will bill your insurance company for services performed and you will be responsible for any differences. We do accept Visa, Mastercard, Discover, Cash, or Check. A $25.00 returned check fee will be assessed to your account for any check returned by your bank.

2) After insurance payment has been received, any remaining balances must be paid within 30 days of the date of the first billing statement unless prior arrangements have been made with the Billing Manager. There will be a statement rebilling fee of $5 for any statement not paid within 30 days. Any balances remaining after 90 days, with a failure to make any arranged payments, will be referred to collection. Once your account is placed with collection you will be responsible for all collect costs associated and will be charged 25% of your outstanding balance or a minimum of $35. Additionally, you will be discharged from the practice and will no longer be able to see the physicians in this medical practice.

3) It is your responsibility to know what your insurance requirements are to obtain any referrals or prior authorizations required by the insurance company prior to treatment. You will be liable for any services denied by the insurance carrier for lack of this documentation. If insurance benefits are mailed to the subscriber, please forward them directly to Wyoming Valley Foot Associates, P.C. along with the Explanation of Benefits.

4) Please note: Medicare and many other insurance plans **do not** cover the cost for routine trimming of corns, calluses or toenails unless you are a diabetic with documented evidence of neuropathy and/or circulation, impairment, or have amyloidosis, multiple sclerosis, Buerger's Disease, atherosclerosis, peripheral vascular disease or polyneuropathy and are under the active care of a physician for these conditions. Medicare patients are required to provide at the time of your appointment the name of your primary care physician and the date you last saw your doctor. This date must be within a 6 month period.

5) In the case of services provided to patient under the age of 18, a parent, guardian or legal representative must accompany the patient to the appointment and will be responsible for payment of any co-pays, deductibles, and/or co-insurance amounts. We do not bill another individual or estranged spouse.

6) We make every effort to remind patients of their appointment at least one day in advance. This is done as a courtesy only. Patients are ultimately responsible for remembering to keep their appointment. We ask that any cancellations be made at least 24 hours in advance. A no show fee of $25 will be charged.

7) A fee will be assessed for completion of any personal disability forms, personal credit life insurance forms, personal attending physician statements, or other miscellaneous forms.

8) No original medical records or x-rays will be released. A reasonable charge for copying your medical records will be assessed. In addition, charges for postage, handling, and faxing charges will be added. Such fees are collected prior to the release of your medical records and/or x-rays.

If you have any questions regarding any of these policies, please contact the billing manager. Otherwise, it will be automatically known that you understand and agree to the above policies. **(NOTE: Even if you refuse to sign this form but elect to receive services--You will still be 100% responsible for any fees incurred.) I have received a copy of office fees schedule.**

_____ _____

Signature Date

Wyoming Valley Foot Associates, P.C

Office Fees

No Show Appointments	$25
Returned Check Fee	$25
Nonpayment of copay	$5
Statement Rebilling Fee	$5
Form Preparation	$10
X-ray copies	$10
Record copies	Per page based on industry standard
Laser	$300
Supplies	Per Item
Collection Fee	25% of outstanding balance/minimum $35

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgment & authorization in refusing we *may not be allowed* to process your insurance claims

Date:_____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_____ _____

Please *print* name of Patient Please *sign* as Patient or Guardian of Patient

_____ _____

Legal Representative/Guardian Relationship of Legal Representative/Guardian

Your comments regarding Acknowledgments or Consents:_____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

__First Name Only __Proper Surname __Other_____

PLEASE LIST THE NAMES OF DOCTORS THAT PARTICIPATE IN YOUR CARE THAT WE MAY RELEASE YOUR MEDICAL RECORDS TO ON REQUEST: _____ _____

PLEASE INDICTATE IF WE HAVE YOUR PERMISSION TO RELEASE YOUR RECORDS TO YOUR INSURANCE COMPANY IF NEEDED FOR PAYMENT __YES __NO (PLEASE BE AWARE THAT BE CHECKING "NO", YOU WILL BE RESPONSIBILE FOR PAYMENT)

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes parents, grandparents, spouses, children, step parents and any care taker who can have access to this patient's records.)

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

__Cell Phone Confirmation __Text Message to my Cell Phone

__Home Phone Confirmation __Email Confirmation

__Work Phone Confirmation __Any of the Above

I AUTHORIZE INFORMATION ABOUT MY HEATLH BE CONVEYED VIA:

__Cell Phone Confirmation __Text Message to my Cell Phone

__Home Phone Confirmation __Email Confirmation

__Work Phone Confirmation __Any of the Above

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO on behalf of this Healthcare Facility via:

__Phone Message __Any of the Above

__Text Message __None of the above(opt out)

__Email

In signing this HIPAA Patient Acknowledgment Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliate companies. We under current HIPPA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's(or representatives) signature on this Acknowledgment but did not because:

It was emergency treatment ___

I could not communicate with the patient ___

The patient refused to sign ___

The patient was unable to sign because ___

Other(please describe) ___

_____

Signature of Privacy Officer