



Reading Foot & Ankle Specialists, PC  
50 Haven Street, Reading, MA 01867  
(P) 781-944-8341  
[www.ReadingFootAnkleSpecialists.com](http://www.ReadingFootAnkleSpecialists.com)

On behalf of the staff and doctors of Reading Foot & Ankle Specialists PC, we would like to take this opportunity to welcome you to our practice.

Enclosed you will find the Patient Information & History Form. Please complete these forms and bring them with your insurance cards, list of medications and referral, if needed.

We look forward to meeting you and offering you the highest quality of care for the medical and surgical management of your foot and ankle issues.

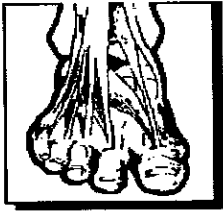
Please contact us if you have any questions or visit our website at [www.Readingfootanklespecialists.com](http://www.Readingfootanklespecialists.com).

Thank you for choosing Reading Foot & Ankle Specialists PC!

Regards,

Dr. Caroline Gauthier, DPM

Dr. Garrett Melick, DPM



# READING

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(781) 944-8341

## PATIENT INFORMATION

Patient's Name \_\_\_\_\_ Date: \_\_\_\_\_

First MI Last

Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Street

City

ZIP

Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Married  Single  Divorced  Separated  Widowed

AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  Male  Female

Which PHARMACY do you use \_\_\_\_\_

Which is the best number to reach you (CHECK ONE)  HOME  WORK  CELL

Primary Care Physician \_\_\_\_\_ Date Last Seen \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_

Street

City

ZIP

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**PRIMARY INSURED (CHECK ONE)** (if self, do not complete the rest of this section)

SELF  SPOUSE  PARENT  CHILD  Other

NAME \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  Male  Female

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_

**INSURANCE** Primary Insurance Co \_\_\_\_\_ Phone \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ POLICY# \_\_\_\_\_ GROUP# \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

If other than self: Policy Holder's Name \_\_\_\_\_

POLICY# \_\_\_\_\_ GROUP# \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Shoe Size \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

REASON FOR TODAY'S VISIT? \_\_\_\_\_ First Date of Onset \_\_\_\_\_

Did this injury occur at work? Yes No If yes, please describe how: \_\_\_\_\_

If yes, have you reported this injury to your employer? \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Have you sought previous treatment for this problem? Yes No

If yes, specify including at-home or professional treatments: \_\_\_\_\_

**PAST MEDICAL HISTORY** (please 'x' if you have had any of these in the past)

<input type="checkbox"/> Anemia	<input type="checkbox"/> Fracture History, please specify: _____	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Fungal Infections	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Gout	<input type="checkbox"/> Rheumatic
<input type="checkbox"/> Breathing problems	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Sciatica/Back Problems
<input type="checkbox"/> Cancer, please specify: _____	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizure Disorder
	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Skin Cancer
<input type="checkbox"/> Cellulitis	<input type="checkbox"/> Gastrointestinal Reflux/Ulcers	<input type="checkbox"/> Stroke
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Kidney Disease/Dialysis	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Deep Vein Thrombosis	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Warts	<input type="checkbox"/> Blood Clots: <input type="checkbox"/> Legs <input type="checkbox"/> Lungs
<input type="checkbox"/> Diabetes: <input type="checkbox"/> Diet <input type="checkbox"/> Pill <input type="checkbox"/> Insulin		

**CURRENT MEDICATIONS**  None  I take the following medications

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I authorize the automated review of medication history Yes \_\_\_\_\_ No \_\_\_\_\_

**ALLERGIES**  No known allergies  I have the following allergies

Penicillin  Sulfa  Adhesive/ TAPE  Cortisone  Codeine  Asprin/NSAIDS  
 Local anesthetics OTHER: \_\_\_\_\_

**PRIOR SURGERIES**

\_\_\_\_\_

**SOCIAL HISTORY**

Do You Smoke?  No I have never smoked  Yes, I have smoked for \_\_\_ years

Not currently, I quit \_\_\_ years ago

Do you drink alcohol?  Yes, everyday(5/7 days/week)  No/Rarely  Yes, occasionally/socially

Substance abuse:  Yes, I currently have a substance abuse problem Specify: \_\_\_\_\_

No, I have never had a substance abuse problem  Yes, I had a past problem

Do you exercise regularly?  Yes, I do the following regular exercise: \_\_\_\_\_

No, I do not exercise regularly

**ARE YOU DIABETIC?**  No If yes, check one:  Diet Controlled  Pill Controlled  Insulin

**FAMILY HISTORY** (Please specify if parents or siblings had any of the following conditions)

Diabetes  Circulatory Problems  Heart Disease  Gout  Blood Clots

Hypertension/High Blood Pressure  Other: \_\_\_\_\_

Complications with anesthesia

**REVIEW OF SYSTEMS** (Please mark 'x' if you have any of these symptoms)**Cardiovascular**

Leg pain when walking  Heart attack  
 Chest pain  Chest pressure/angina  
 Leg swelling  Cold hands/feet  
 Leg cramps  High blood pressure

**Eyes, Ears, Mouth, Nose, Throat**

Dizziness  Glaucoma  
 Hearing loss  Cataracts  
 Vision problems

**Gastrointestinal**

Abdominal pain  Indigestion  
 Blood in stool  Vomiting  
 Ulcers  Diarrhea  
 Heartburn

**Hematologic**

Sickle cell disease  Clotting disorder  
 Anemia  Bleeding problems  
 Use of blood thinners

**Musculoskeletal**

Back pain  Joint swelling  
 Muscle weakness  Sciatica  
 Neck pain  Joint stiffness  
 Joint pain  Joint instability  
 Arthritis

**General**

Nausea  Chills  
 Fever  Weight gain/loss

**Endocrine**

Diabetes  Thyroid problems

**Genitourinary**

Currently pregnant  Kidney stones  
 Kidney disease  Excessive urination  
 Urinary tract infections

**Integumentary**

Athlete's foot  Nail abnormalities  
 Keloids  Itchiness  
 Dry, scaly skin  Lower leg ulcer  
 Rash

**Neurological**

Tingling/numbness  Weakness  
 Seizures  Tremors  
 Paralysis

**Respiratory**

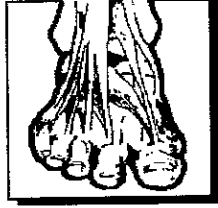
Difficulty breathing  Snoring  
 Coughing  
 Shortness of breath  
 Wheezing

**PLEASE READ AND SIGN:** The above information is correct to the best of my knowledge. I understand that throughout my treatment at Caroline

Gauthier, DPM I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

\_\_\_\_\_  
 Patient/Parent/Guardian

\_\_\_\_\_  
 Date



# READING

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## FINANCIAL POLICY

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. We accept Medicare benefit amounts. 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.

**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.

**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 full payment of these services at the time of service.

**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.

**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:** All co-payments, co-insurance, or deductible amounts 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 portion of insurance benefits at each visit. As a courtesy, our office does verify benefits with your insurance carrier; however, the insurance agreement is a contract between you and your insurance carrier. It is recommended that you verify your benefits with your carrier as well.

**PHYSICIAN PHONE CALLS:** Phone calls with our physician(s) are a billable service, may be billed to your insurance company/companies, and are subject to your insurance benefits. You are responsible for your portion of insurance benefits for physician phone calls.

**NON-CUSTOM DURABLE MEDICAL EQUIPMENT RETURNS:** If a patient is unsatisfied with any non-custom Durable Medical Equipment item, it must be returned within 30 days per Medicare guidelines. Returns after 30 days will not be permitted. The item will only be accepted as a return if it is in returnable condition. Any custom durable medical equipment item may not be returned for any reason.

**COPY FEE:** We will provide copies of patient records at the patient's request. Copies of records may be subject to a \$0.05 per single page copy fee. You will bear complete financial responsibility for any fee(s) incurred.

**CANCELLED/MISSED APPOINTMENT FEE:** If you cannot keep your appointment time, please call our office at least 60 minutes prior to your scheduled appointment time. There may be a **\$25 fee** for any appointment cancelled or rescheduled within 60 minutes of the scheduled time. Additionally, there may be a **\$25 fee** if you miss a scheduled appointment. If you miss 3 or more appointments, you may be required to pay a \$50 deposit to hold any future appointment time slots. If you arrive late for an appointment, we may need to reschedule your appointment. You will bear complete financial responsibility for any fee(s) incurred. Repeated missed or late appointments may result in dismissal from our practice.

**COLLECTIONS FEE:** 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 will be forwarded to our collection agency. If your account is sent to a collections agency, a **35% fee** will be added to your account. You bear complete financial responsibility for any fee(s) incurred.

Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA/MasterCard/Discover. An additional \$25.00 will be added to your statement if the check is returned from your bank. In the event that your insurance company sends payment to you, the patient, it should be forwarded to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* to Reading Foot & Ankle Specialists, PC. for medical services provided. I agree to pay Reading Foot & Ankle Specialists, PC. any balance unpaid by my insurance carrier for myself or the below named person.

**PRIVACY STATEMENT:** Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

**PATIENT ACKNOWLEDGE OF 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 (or had the opportunity to read if I so chose) and understand the Notice and agree to its terms.

**Assignment of Benefits**

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Reading Foot & Ankle Specialists, P.C.** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees **AT THE TIME OF SERVICE**. 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.

**I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms:**

**PRINT Patient Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**If patient is under 18, please complete the following for the FINANCIALLY RESPONSIBLE PARTY:**

**PRINT Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_