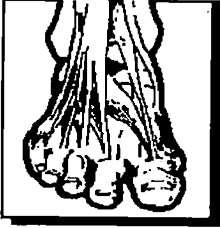


Reading Foot & Ankle Specialists, PC
50 Haven Street, Reading, MA 01867
(P) 781-944-8341
www.ReadingFootAnkleSpecialists.com

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.

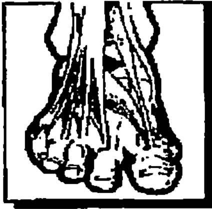
Please contact us if you have any questions or visit our website at www.Readingfootanklespecialists.com.

Thank you for choosing Reading Foot & Ankle Specialists PC!

Regards,

Dr. Caroline Gauthier, DPM

Dr. Anna Kakizaki, DPM



READING

FOOT & ANKLE SPECIALISTS, PC

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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)

__Anemia
__Arthritis
__Autoimmune Disease
__Bleeding Disorders
__Breathing problems
__Cancer, please specify:
____
__Cellulitis
__Congestive Heart Failure
__Deep Vein Thrombosis
__Neuropathy
__Diabetes: __Diet __Pill __Insulin

__Fracture History, please specify:
____
__Fungal Infections
__Gout
__Heart Disease
__High Blood Pressure
__High Cholesterol
__ Gastrointestinal Reflux/Ulcers
__Kidney Disease/Dialysis
__Liver Disease
__Warts

__Osteoporosis
__Peripheral Vascular Disease
__Psoriasis
__Rheumatic
__Sciatica/Back Problems
__Seizure Disorder
__Skin Cancer
__Stroke
__Thyroid Problems
__Varicose Veins
__Blood Clots: __Legs __Lungs

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

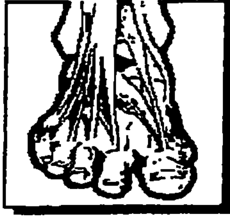
Respiratory

__Difficulty breathing
__Snoring
__Coughing
__Shortness of breath
__Wheezing

PLEASE READAND 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:** ________________________
Date: ________________________

Relationship to Patient: ________________________