Date: \_\_\_\_\_\_\_\_\_\_\_ **Connecticut Foot Specialists, P.C.** Page 1 of 5

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ Last First MI

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street City State Zip

Sex\_\_\_\_\_\_ Age \_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_E-mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status S\_\_\_\_\_ M\_\_\_\_\_ D \_\_\_\_\_ W \_\_\_\_\_ Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name Address Phone

Relationship to Patient (please check one) \_\_\_\_\_Self \_\_\_\_\_\_ Parent \_\_\_\_\_Spouse \_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Used: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office? Internet Family Paper Friend Physician

*If you were referred, please provide the following information about the referral source:*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Internet (please specify): Google Yahoo Bing Yelp Other\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Reason for your visit (please be specific):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Right Foot \_\_\_\_\_ Left Foot \_\_\_\_\_ Both Feet \_\_\_\_\_

Are your feet painful? Yes \_\_\_\_\_ No \_\_\_\_\_

How long has this been a problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Related? Yes \_\_\_\_\_ No \_\_\_\_\_\_

What treatments have you tried?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any past problems with your feet and/ or ankles?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any past surgical procedures on your feet and/or ankles? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shoe Size \_\_\_\_\_\_\_\_\_ Current Weight \_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_ Have you worn orthotics? Yes No

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Page 2 of 5

**GENERAL HEALTH HISTORY**

Do you have diabetes? Yes \_\_\_\_\_ No \_\_\_\_\_ On Insulin? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had any serious illnesses? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you had any major surgeries? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what type : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have an artificial joint(s)? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a Heart Valve Implant? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_\_\_ If yes, how much: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many a day? \_\_\_\_\_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_\_\_\_\_

Previously smoked? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many a day? \_\_\_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_\_\_\_

Employment: Sit at work \_\_\_\_\_\_\_ Stand at work \_\_\_\_\_\_\_ Stand & walk at work \_\_\_\_\_\_\_ N/A \_\_\_\_\_\_\_\_\_

**ALLERGIES** (Please check off or note **any** allergies)

\_\_\_\_Antibiotics (type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ No Known Allergies

\_\_\_\_ Aspirin \_\_\_\_Codeine \_\_\_\_Sulfa \_\_\_\_ Betadine (Iodine) \_\_\_\_Latex \_\_\_\_Penicillin \_\_\_\_Seafood

\_\_\_\_Ibuprofen (Advil, Motrin) \_\_\_\_Local anesthetics (Novocaine, Lidocaine) \_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS** (**please list below**, including non-prescription or herbal supplements) \_\_\_\_\_NONE (check if none)

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

**Check any of the following you have, or have had a problem with:**

\_\_\_\_ Anemia \_\_\_\_ Diabetes \_\_\_\_ Lung Disease \_\_\_\_ Stomach Ulcers

\_\_\_\_ Arthritis \_\_\_\_ Gout \_\_\_\_ Neurological Disorder \_\_\_\_ Thyroid Disorder

\_\_\_\_ Asthma \_\_\_\_ Heart Disease \_\_\_\_ Phlebitis \_\_\_\_ Unexplained Weight Loss

\_\_\_\_ Bladder \_\_\_\_ High Blood Pressure \_\_\_\_ Prolonged Breathing \_\_\_\_ Frequent Infections

\_\_\_\_ Cancer \_\_\_\_ High Cholesterol \_\_\_\_Rheumatoid Arthritis \_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ COPD \_\_\_\_ Kidney Disease \_\_\_\_ Skin \_\_\_\_ None of the above

**FAMILY HISTORY**

**Circle** if any blood relatives have had: Arthritis Cancer Diabetes Heart Disease High Blood Pressure Kidney Disease

Any other pertinent information I should know? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Page 3 of 5

**Financial Policy for Connecticut Foot Specialists, P.C.**

Thank you for choosing our office. We are committed to serving you with skilled and high quality care.

\_\_\_\_\_ (Initial) I give Connecticut Foot Specialists, P.C. permission to examine me and provide medical services. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

\_\_\_\_\_ (Initial) **CO-PAYS:** Are due at the time of service. Co-pays will not be billed.

\_\_\_\_\_ (Initial) **SELF PAY:** Payment is due in full at the time of service if you do not have health insurance.

\_\_\_\_\_ (Initial) **MEDICARE:** We are a participating Medicare provider. Medicare and your secondary insurance will be billed for you. You are responsible for your co-pay or any deductible amounts.

\_\_\_\_\_ (Initial) **SECONDARY INSURACE:** Your medical claim will be forwarded to your secondary insurance after payment and/or explanation is received from your primary insurance company.

\_\_\_\_\_ (Initial) **REFERRALS/AUTHORIZATIONS:** We are required to follow guidelines of your managed care plan with mandates that when you visit a specialist, you may need to have a referral from your primary care physician prior to seeking care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of visit. If a referral is not provided **you are** fully responsible for all services provided if denied by the insurance company.

**\_\_\_\_\_** (Initial) All missed appointments will be charged a $25.00 NO SHOW fee. Our office calls the day before to remind you of your appointment.

\_\_\_\_\_ (Initial) **PATIENT BILLING:** I agree to pay Connecticut Foot Specialists, P.C. for any amount due after insurance payment has been made by my carrier and any contractual adjustments have been credited or the full amount of all bills incurred by me or the below named if there is no health coverage. You will be sent up to three notices for your financial responsibility. After the third and last notice, your account will be forwarded to collections and charged a 15% collection fee.

\_\_\_\_\_ (Initial) **ASSIGNMENT OF BENEFITS:** I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Connecticut Foot Specialists, P.C. 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.

\_\_\_\_\_ (Initial) I understand that it is my responsibility to inform this office, immediately, if there are changes to my health insurance information.

I authorize the use of the signature below on all insurance submissions. I have read the above policy regarding my financial responsibility to Connecticut Foot Specialists, P.C. for providing medical services to me or the below named patient. I agree to pay Connecticut Foot Specialists, P.C. for any amount due after insurance payment has been made by my carrier and any contractual adjustments have been credited or the full amount of all bills incurred by me or the below named if there is no health coverage.

Patient/ Financial Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Page 4 of 5

**CONNECTICUT FOOT SPECIALISTS, P.C.**

**Summary of Notice of Privacy Practices**

The notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

**Uses and Disclosure of Health Information:**

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

**Uses and Disclosures based on your Authorization:**

Except as noted in more detail in the Notice of Privacy Practices, we will not use or disclose your health information, social security numbers of other financial information without your written consent.

**Uses and Disclosures Not Requiring Your Authorization:**

In the following circumstances, we may disclose your health information without your written authorization:

* To family members or close friends who are involved in your care;
* For certain limited research purposes;
* For purposes of public health and safety;
* To government agencies for the purposes of their audits, investigations and other oversight activities;
* To government authorities to prevent child abuse or domestic violence;
* To the FDA to report product defects or incidents;
* To the law enforcement authorities to protect public safety or to assist in apprehending criminals;
* Where required by court orders, search warrants, subpoenas and as otherwise required by law.

**Patient Rights:**

As our patient, you have the following rights:

* To have access to and/or a copy of your health information;
* To receive an accounting of certain disclosures we have made of your health information;
* To request restrictions as to how your health information is used or disclosed;
* To request that we communicate in confidence;
* To request that we amend your health information;
* To receive a notice of our privacy practices. A copy of the complete NOTICE is available upon request.

I acknowledge that I was provided a copy of the Notice of Privacy Policy from Connecticut Foot Specialists, PC and that I have read and understand the notice as mandated by HIPPA (Health Insurance Portability and Privacy Act).

Patient/ Financial Responsible Party Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/ Financial Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_