

PERSONAL INFORMATION

Pioneer Podiatry, P.C.

Patient: _____

Address: _____

City/Town: _____ Zip Code: _____

Sex: _____ Age: _____ DOB: _____

Race: Caucasian Black Asian American Indian/Alaska

Ethnicity: Hispanic Non-Hispanic Decline

Language: Arabic German Korean Portugese Tagalog
 Cantonese Hindi Mandarin Romanian Ukranian
 English Italian Persian Russian Urdu
 French Japanese Polish Spanish Vietnam

Other: _____

Soc.Sec.#: _____

Occupation: _____

Employed by: _____

Home phone:() _____

Business phone:() _____

Mobile phone:() _____

Email: _____

Marital status: _____

Spouse/kin: _____

Phone: _____

Occupation: _____

Employed by: _____

Referring M.D.: _____ Date last seen: _____

Address: _____
 (street) (city) (state) (zip)

BILLING INFORMATION

MEDICAL INSURANCE	SUBSCRIBER / DOB	RELATIONSHIP	CERTIFICATE #
BC/BS Plan _____	/		
Medicare			
Medex			
Welfare (Medicaid)			
Other: _____	/		
	Suffix: _____	Group #: _____	

Address: _____
 (street) (city) (state) (zip)

RESPONSIBLE PARTY for MINOR CHILD WORKMAN'S COMPENSATION

Parent's Name: _____	Party to be billed: _____
Address: _____	Address: _____
Phone: _____	Claim/File #: _____ Date of Accident: _____

EXTENDED AUTHORIZATION

I hereby authorize Pioneer Podiatry, P.C. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Pioneer Podiatry, P.C. all payments for medical services rendered to myself or my dependents. I am aware that it is my obligation to know my insurance company's policies and that I am responsible for payment if I have not fulfilled their requirements.

Signature: _____ Date: _____

CONSENT FOR TREATMENT

I hereby request and voluntarily consent to such office care, including routine diagnostic procedures and medical treatment as may be deemed necessary by Pioneer Podiatry, P.C. and/or his designees.

Signature: _____ Date: _____

DeCaro Total Foot Care Center
Podiatric Medicine & Foot Surgery
Louis J. DeCaro, DPM
Daniel P. Paknia, DPM
www.DeCaroPodiatry.com

10 West Street

West Hatfield, MA 01088

Telephone: (413) 397-8900

Fax: (413) 247-6151

Financial Policy

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

CO-PAYS. Co-pays are due at the time of service. A fee of 15.00 will be added if billed by **Wachusett Medical Billing**.

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

MEDICARE. We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. You are responsible for co-payment or deductible amounts as stated by Medicare and your secondary insurance company.

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.

REFERRALS/AUTHORIZATIONS. You are responsible for obtaining a referral or authorization, if required, from your primary physician. You may be financially responsible for the charges if denied due to absence of a referral/authorization. Your scheduled visit may also be rescheduled due to the absence of a referral/authorization.

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 to case basis. We accept the following payment methods: Cash, Check or VISA/Mastercard. An additional \$25.00 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.

BILLING SERVICE. Our office has contracted **Wachusett Medical Billing** to provide insurance and patient billing services. Their phone number will be in your statement should you have any questions regarding your bill.

I have read the above policy regarding my *financial responsibility* to the DeCaro Total Foot Care Center for providing medical services to me or the below named patient. I agree to pay the DeCaro Total Foot Care Center 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 insurance coverage.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

PRINT Patient Name: _____ Signature: _____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____

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Medical History

Please fill out ALL sections

Reason for Visit Today (Include all orthopedic past or present complaints including **foot, ankle, knee, hip**, and **back** complaints and any pertinent family history for each category):

Foot: _____

Ankle: _____

Knee: _____

Hip: _____

Back: _____

Foot Pain Specifically:

Type: _____

Duration: _____

Location: _____

Date first foot pain symptoms occurred: _____

Have you ever worn any Orthotics and/or Lower Extremity Bracings (If so what, when, and for how long):

List any medications you are currently taking (prescription or non-prescription):

Current Pharmacy: _____ Address: _____ Phone: _____

Athletic activities or exercise regimens in which you participate (Please list and indicate frequency):

Please list any and all allergies and describe the reaction (Omission will assume no Allergies):

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Pioneer Podiatry, PC

Acknowledgment Form HIPPA Privacy Practices

Print Patient Name: _____

By signing this, I acknowledge that I have received a copy of Pioneer Podiatry, PC's Notice of Privacy Practices.

Signed: _____

If the signature above is not the patient's, please specify your relationship to the patient: _____

Date: _____

I authorize the release of my private medical information to the following persons:

_____ relationship to patient _____

_____ relationship to patient _____

_____ relationship to patient _____

Patient Signature _____ Date _____

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Do you or any family member have, or have you ever had any of the following?

Please write in "S" for Self, "FM" for Family, or "B" for both.

Corns and Calluses		Athlete's Foot		Bunions		Cramps or Numbness	
Ingrown Toenails		Flat Feet		Heel Pain		Swelling in Ankles or Feet	
Ankle Pain		Plantar Warts		Tired Feet		Gout	
High Blood Pressure		Cancer		Diabetes		Drug Use	
Heart Trouble		Anemia		HIV		Psychiatric Treatment	
Hepatitis		Seizures		Arthritis		Other	
Stroke		Smoking		Asthma		Other	

Please list any serious illnesses (including specific heart conditions), hospitalizations and/or operations you have had:

Consent to Treatment

I hereby grant consent to Louis J. DeCaro, and/or Daniel P. Paknia, DPM to give medical treatment as requested by me. I also authorize Louis J. DeCaro, and/or Daniel P. Paknia, DPM to release any information acquired in the course of my examination or treatment to my insurance carrier, and authorize payment directly to Louis J. DeCaro, and/or Daniel P. Paknia, DPM of all surgical and/or medical benefits, if any otherwise payable by me for services. I understand that I am financially responsible for co-payments and other charges not covered by any insurance.

 Signature of Patient (or Legal Guardian if under 18 years of age)

 Date