WELCOME TO OUR OFFICE

Date: ____________________ Name: ____________________ Address: ____________________ ____________________ City State Zip Home Phone #: ____________________ Cell Phone #: ____________________ Date of Birth: ____________________ Age: __________ Marital Status: S M W D Sex: M F Height: ______ Weight: ______	Soc. Sec. # _________-_________-_________ Occupation: ____________________ Employer: ____________________ Address: ____________________ ____________________ City State Zip Work Phone #: ( )____________________
	Spouses Name: ____________________ Spouses D.O.B.: ____________________ Employer: ____________________ Address: ____________________ ____________________ City State Zip Work Phone #: ( )____________________
Ethnicity: __________ Race: __________ Email:____________________	Language: ____________________ Translator Needed: ____________________
Insurance Type: ____________________ Pharmacy: Name: ____________________ Town: ____________________	How were you referred to the practice? Doctor (name) ____________________ Ins. Book __________ Friend __________ Newspaper __________Internet__________

Have you had any previous treatment by another podiatrist? YES / NO	When: __________ __________	Reason: __________ __________

Describe your foot problem: ____
____

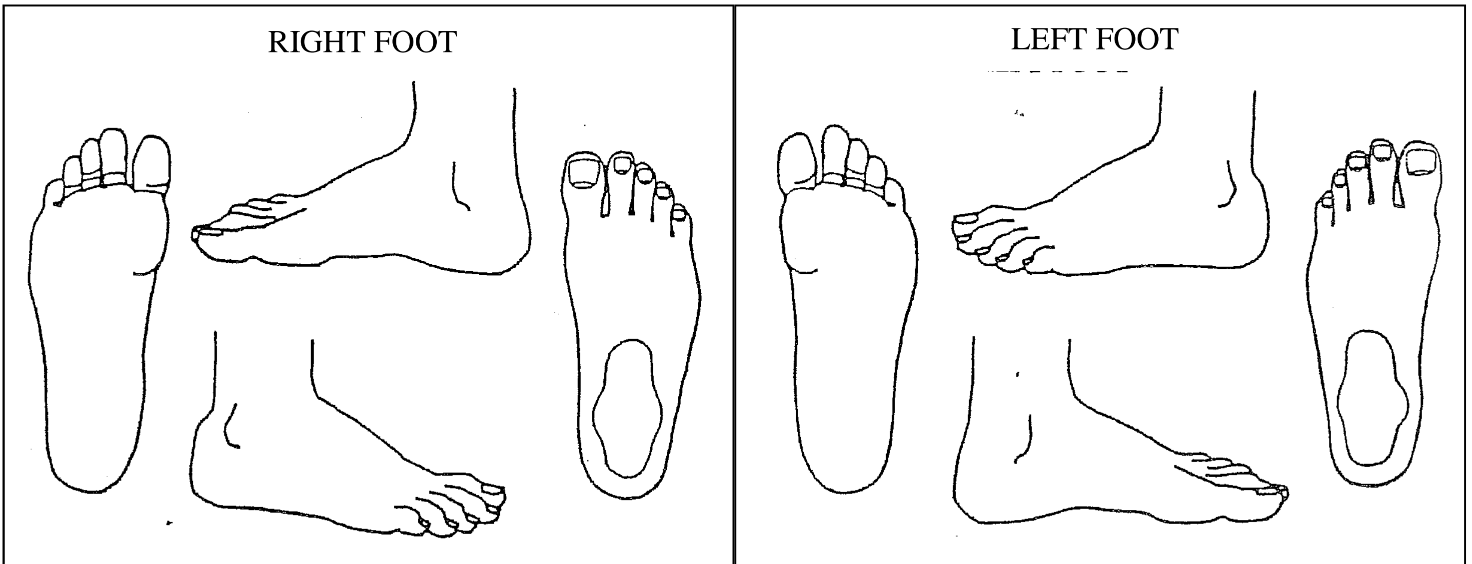
This condition has been present for: Days ______ Weeks ______ Months ______ Years ______

List <u>All</u> medications currently being Taken: ____________________ ____________________ ____________________ ____________________ Family Doctor: ____________________ Address: ____________________ ____________________ City State Zip Phone #: ( ) ____________________	Are you allergic to any of the following: Yes No Maybe Novocain _____ _____ _____ Penicillin _____ _____ _____ Aspirin _____ _____ _____ Adhesive Tape _____ _____ _____ Other Medications (specify) __________ ____________________ Foods (specify) ____________________ ____________________ Symptoms: ____________________

RELEASE OF INFORMATION: I authorize the release of medical information necessary to process any claim submitted by Foot & Ankle Specialists of CT. I authorize payment of medical benefits to Foot & Ankle Specialists of CT.

SIGNATURE: ____________________ WITNESS: ____________________ DATE: __________

Please Mark Area of Concern



MEDICAL HISTORY: Do you have or have you ever had? (Please check)

	YES	NO	Family History		YES	NO	Family History
Anemia	_____	_____	______	High Blood Pressure	_____	_____	______
Arthritis	_____	_____	______	Kidney Problems	_____	_____	______
Bleeding Problems	_____	_____	______	Liver Problems	_____	_____	______
Blood Transfusion	_____	_____	______	Pacemaker	_____	_____	______
Circulation Problems	_____	_____	______	Phlebitis	_____	_____	______
Diabetes	_____	_____	______	Rheumatic Fever	_____	_____	______
Epilepsy	_____	_____	______	Sickle Cell Anemia	_____	_____	______
Gout	_____	_____	______	Stroke	_____	_____	______
Heart Murmur	_____	_____	______	Ulcers (Stomach)	_____	_____	______
Heart Trouble	_____	_____	______	Joint Replacement Surgery	_____	_____	______
Hepatitis	_____	_____	______	Other ____________________________________			

1. Have you ever been hospitalized? YES / NO Reason: ____

2. Have you ever had surgery? YES / NO List Procedure ____

3. Are you being treated for any illnesses? YES / NO List Illnesses: ____

4. Do you smoke cigarettes? YES / NO Packs Per Day: ________________ Years Smoking: ______

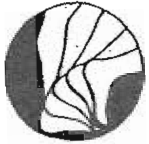
5. Do you consume alcohol? YES / NO List Frequency: ________ Approximate Quantity Consumed: _______

I hereby give permission to Foot & Ankle Specialists of CT, PC to examine and administer treatment as may be deemed necessary in the diagnosis and/or treatment of my foot and related problem(s).

______________________________________ SIGNATURE

_________________ Date

Relationship to patient (if patient is a minor): ___________________________



FOOT & ANKLE SPECIALISTS of CONNECTICUT, P.C.

• Danbury • Plainville • New Milford •

Paul F. Dobies, DPM, FACFAS
Joseph R. Treadwell, DPM, FACFAS

Elinor Leili
Business Manager

Charles W. Scott, DPM
Christian E. Davis, DPM

FINANCIAL POLICY

PATIENTS WITH INSURANCE COVERAGE

We will be glad to help you obtain the appropriate benefit from your primary insurance carrier and bill your carrier as a courtesy to you. However, you are responsible for the payments of the account. We will be happy to request a pre-estimate of benefits from your insurance carrier if you request us to do so. Routine treatment is generally performed without submitting a request for pre-estimate of benefits.

Portions of the bill may not be paid by the insurance company and are to be paid by you. **Deductibles and co-payments are your responsibility.** Please be advised that as a courtesy to you we will bill your secondary insurance company.

If you are having treatment over a period of time, we appreciate payment during the course of treatment. Any non-covered services are due at the time they are rendered.

PATIENTS WITHOUT INSURANCE COVERAGE

Patients without insurance coverage are required to pay for services as rendered. We accept Mastercard, Visa and personal check payments.

ADDITIONAL TERMS

Appointments cancelled less than 24 hours notice are subject to a $25.00 cancellation charge. Checks returned by your bank are subject to a $20.00 processing charge. Accounts are due 30 days from the date of billing and are subject to a finance charge at the rate of 1.5% per month (18% per annum) if not paid in a timely manner. If your account is referred for collection, you will be responsible for collection costs in the amount of 30% of the outstanding balance, together with court costs and reasonable attorney's fees.

We would like to take this opportunity to welcome you to our office and assure you that we will do our utmost to provide you with the best care possible.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF THE OFFICE OF FOOT & ANKLE SPECIALISTS OF CT, P.C.

X______________________________________   ______________________

SIGNATURE OF PATIENT OR GUARDIAN   TODAY'S DATE

6 Germantown Road
Danbury, CT 06810
Tele: (203) 748-2220

21 Cooke Street
Plainville, CT 06062
Tele: (860) 747-2200

7 Pickett District Road
New Milford, CT 06776
Tele: (860) 355-3139

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Joseph R. Treadwell, DPM, FACFAS

Elinor Leili
Business Manager

Christian E. Davis, DPM

ACKNOWLEDGMENT OF RECEIPT of NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

______________________________ ______________________

Patient Name (please print) Date

____

Parent or Authorized Representative (if applicable)

____

Signature

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached 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 Disclosures 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 stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

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 health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for 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 law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the 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 with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.