DeCaro
Total Foot Care Center
Podiatric Medicine and Foot Surgery

Louis J. DeCaro, DPM
Daniel P. Paknia, DPM
Shaneekwa Perkins, DPM

First Name: _____ **M. I.**_____ **Last Name:** _____

Address: _____

City/Town: _____ **State**:_____ **Zip Code:** _____

Gender: _____ **Age:** _____ **Birthdate:** _____

Home Phone: _____ **Cell Phone:** _____

Race: O Caucasian O Black O Asian O Amer. Indian or Alaska Native O Hawaiian/Pac. Isl.

Ethnicity: O Hispanic O Non-Hispanic O Not Specified

Primary Language: O Arabic O German O Korean O Portuguese O Tagalog O Hindi
O Italian O English O Cantonese O Mandarin O Persian O Russian O Urdu
O Romanian O Ukrainian O French O Polish O Spanish O Japanese O Vietnam
Other: _____

Occupation: _____ Employer: _____

Primary Care Physician: _____ **Date Last Seen:** _____

Referring Source: _____

Responsible Party for Minor:

Name: _____ Phone: _____

Address: _____

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:** _____

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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 (If not applicable, please write "none"):

_____

_____

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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 ,"M" for Mother, "F" for Father

AIDS/HIV		Congestive Heart Failure		Hypertension		PVD	
Alcoholism		Depression		Kidney Problems		Rheumatoid Arthritis	
Alzheimer's		Diabetes		Mitral Valve Repair		Seizures	
Anemia		DVT		Multiple Sclerosis		STD's	
Arthritis		Emphysema		Myocardial Infarction		Stroke	
Asthma		Gout		Osteoporosis		Thyroid Disorder	
Cancer		Hepatitis		Phlebitis		Ulcer	
Cardiac Disease		Herpes		Psychiatric Problems		Other:	

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

_____

_____

Names of Specialists treating you: Cardiologist _____ Vascular _____

Endocrinologist _____ Dermatologist _____ Oncologist _____

Rheumatologist _____ Neurologist _____ Other _____

Consent to Treatment

I hereby grant consent to Louis J. DeCaro, Daniel P. Paknia, and/or Shaneekwa S. Perkins, DPM to give medical treatment as requested by me. I also authorize Louis J. DeCaro, Daniel P. Paknia, and/or Shaneekwa S. Perkins, 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, Daniel P. Paknia, and/or Shaneekwa S. Perkins, 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

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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**.

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 by your insurance. Insurance referrals are to be generated by your primary physician prior to your appointment. 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/DISCOVER. 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.

NO SHOW POLICY: Our office will call to remind you of your appointment. If you fail to cancel your appointment within 24hours of your scheduled time of arrival, you will be billed $25.00/$50.00 no show fee.

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.
While we are contracted with your carrier, this does not guarantee payment. Coverage is subject to all of the terms & conditions of the member's contract.
I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

PRINT Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____

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PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date
_____	_____	_____	_____

Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Print Name: _____ **Print Name:** _____

Relationship to Patient: _____ **Relationship to Patient:** _____

Phone Number: _____ **Phone Number:** _____

Request to Receive Confidential Communications:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the means that I have listed below.

Home Telephone Number:

_____

_____**OK to leave message with detailed information**

Email Address:

_____

_____**OK to Send Email to Address Above**

Cell Phone Number:

_____

_____**OK to leave message with detailed information**

Work Phone Communication:

_____

_____ **OK to leave message with detailed information**