DeCaro
Total Foot Care Center
Podiatric Medicine and Foot Surgery

Louis J. DeCaro, DPM
Daniel P. Paknia, DPM
Phone: 413.397.8900

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

Mailing Address: _____

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

Male:__ Female:__ Transgender Male/FTM__ Transgender Female/MTF__ Gender Queer__ Other:_____

Birthdate: _____ **Age:**_____

Primary Phone: _____ **Secondary 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, DPM/ Daniel P. Paknia, DPM to give medical treatment as requested by me. I also authorize Louis J. DeCaro, DPM/ 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, DPM/ 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

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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**

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Patient Financial Responsibility

PLEASE INITIAL EACH LINE

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, examinations, procedures, injections, x-rays, durable medical equipment and any other services ordered by the doctor or staff._____

(Be aware that some treatments may be considered a surgical procedure by insurance, and must be billed as a surgery. Also, some injections are considered surgical as well and you could be billed for these. If your policy has a surgical deductible, you are responsible for meeting that deductible. Radiology exams will be billed to your insurance. Some insurance require a copayment/deductible and/or co-insurance. Durable Medical Equipment that is billed to your insurance may require a copayment/deductible and/or co-insurance. Please verify coverage with your insurance carrier.) _____

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance. _____

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, prior authorization requirements or any other type of benefit limitations for the services I received and I agree to make payment in full. _____

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered. _____

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full. _____

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._____

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 required to pay $25.00 for the first missed appointment and $50.00 for the second no show. This does need to be paid before the appointment can be rescheduled. _____

By initialing & signing this form, I consent to the use and disclosure of protected health information about me for treatment, payments and health care operations, and /or as required by law. DeCaro Total Foot Care Center provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Patient/Printed Name/DOB:_____

Patient/Guardian Signature:_____