GREENVILLE FOOT AND ANKLE SPEICALISTS

David M. Colannino, DPM, FACFAS

Dominic J. Roda, DPM

PATIENT REGISTRATION

Patient Name:____
(Last) (First) (Initial)

Address: ____

City: ________________ State: _______ Zip:________ Sex: M / F

Home Phone:____________________Cell Phone:_______________

Email Address: ____________________________________

Age: ___ Birthdate: __________SS#______________Marital Status ____

Patient Employed By: _____________ Occupation:_________________

Business Address: ______________________ Phone:_____________

Who may we thank for referring you? _______________________

In Case of emergency who should be notified_______________________

Relation:______________ Phone_______________

Primary Care Physician:_______________ PCP phone :___________

Pharmacy

Name & Address__________________________ State____

Phone___________

Insurance

Please attach your insurance cards at the top of the clipboard

Assignment and Release

I, the undersigned, certify that I (or my dependent) have current insurance coverage with ____________________
And assign directly to David M. Colannino, DPM, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

____________________ __________________ ____________
(Responsible Party) (Relationship) (Date)

David M. Colannno, D.P.M.
Dominic J. Roda, D.P.M.

PERSONAL HEALTH INFORMATION

Do you now or have you ever had:

	YES	NO		YES	NO		YES	NO
DIABETES	____	____	RHEUMATIC FEVER	____	____	ANEMIA	____	____
HEART DISEASE	____	____	RHEUMATOID ARTHRITIS	____	____	PHLEBITIS	____	____
HIGH BLOOD PRESSURE	____	____	GOUT	____	____	HEPATITIS	____	____
STROKE	____	____	EPILEPSY	____	____	ASTHMA	____	____
GLAUCOMA	____	____	THYROID PROBLEMS	____	____	AIDS/HIV	____	____
KIDNEY DISEASE	____	____	LIVER DISEASE	____	____	CANCER	____	____
BLEEDING PROBLEMS	____	____	HEART MURMUR	____	____	GI ULCER	____	____

What medications are you presently taking?

NAME	DOSE	FREQUENCY
______________________	______________	______________________
______________________	______________	______________________
______________________	______________	______________________

Do you have allergies to any medications? _______ *If yes, to which:*

______________________ ______________ ______________________

Social history:

Smoke. Yes / No How many packs per day? ___________ How many years? ___________

Drink: Yes / No How many drinks per day? ___________ How many years? ___________

Drug Abuse: Yes / No If yes, what type(s) ______________________________

Surgical History:

Family History:

Please circle if any of your blood relatives have or have ever had:

DIABETES	RHEUMATIC FEVER	ANEMIA
HEART DISEASE	RHEUMATOID ARTHRITIS	PHLEBITIS
HIGH BLOOD PRESSURE	GOUT	HEPATITIS
STROKE	EPILEPSY	ASTHMA
GLAUCOMA	THYROID PROBLEMS	AIDS/HIV
KIDNEY DISEASE	HEART MURMUR	CANCER
BLEEDING PROBLEMS	LIVER DISEASE	GI ULCER

Please briefly describe your foot problem(s):

____

David M. Colannino, D.P.M.
Dominic J. Roda, D.P.M.

Patient Financial Policy

We are dedicated to providing the best possible care and service to you and regard your complete understanding our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures that we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.
- There is a charge of **$40.00** for all missed/broken appointments, or appointments not cancelled with 24 hour notice. This must be paid before any further appointments will be scheduled. Your insurance company does not cover this fee.
- There is a service fee of **$25.00** for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party______________________________ **Date** _______________

Printed Name ______________________________

Witness ______________________________________**Date**_______________

Printed Name______________________________________

__________**Patient initials to indicate copy received**

David M. Colannino, D.P.M.
41 Sanderson Road, Suite 207
Smithfield, RI 0291

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____________ ____ ____________________ have been provided a copy of the Notice of Privacy Practices.

______________________________ ____________________

Signature of Patient Date