

364 East Main Street
Ansonia, CT 06401

4 Corporate Drive Suite 384
Shelton, CT 06484

P: 203-734-4806

Thank you for choosing Yale Podiatry Group, please read this packet in its entirety.

We will bill your insurance as a courtesy to you with a copy of the insurance card you provide. All primary and secondary insurance information must be provided at time of service; you are responsible to notify our office of any changes to your insurance throughout the year. If the insurance information that is provided is incorrect, it will be your responsibility to guarantee payment. If you do not have your insurance card, we will reschedule your appointment when you have this information available. It is your responsibility to keep track of requirements of your plan. Each plan has different stipulations regarding how often services may be rendered and, more importantly, where those services may be performed. If you do not inform us of any special requirement in your contract and we subsequently order services, such as lab work or hospitalization, that are not covered, the selected medical facility will have no choice but to bill you for those charges. Payment for those charges is then your responsibility.

UCR (usual, customary, and reasonable) Fees: We are committed to providing the best treatment possible and we charge what is usual and customary for our area. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance company's arbitrary determination of UCR fees.

Workers Compensation: STOP! If you are here because of a work-related injury, please notify the front desk. Additional paperwork is required.

HMO/PPO/Commercial: All co-payments are due at the time of service no exceptions, we are participating physicians with most, but not all plans. You are responsible for verifying what your insurance plan will cover and that we are providers for your plan. You are responsible for any co-insurance and deductible.

Medicare and Medicare Advantage: We accept Medicare assignment. If you have supplemental insurance, we will submit the claim for you. If you do not have a secondary insurance, your deductible or coinsurance will be due at time of service.

Self-Pay: A minimum deposit of \$200 or the actual charge, whichever is less, is due at the time of service. Currently Yale Podiatry Group offers a 20% prompt pay discount for charges that are paid in full. Any subsequent visit charges will be due at time of service. If you cannot pay in full, you will need to set up and adhere to a payment plan with our billing department. We accept Visa, MasterCard, American Express, Discover, cash and checks with a valid driver's license.

Insurance Referrals: Referrals are your responsibility to obtain prior to your visit, if required. If no referral is obtained prior to your visit we must reschedule your appointment otherwise, you may be responsible for payment.

Delinquent Accounts: All balances are due within 30 days of your statement date otherwise you will be charged a \$10.00 late fee. We will not be involved in negotiating payment, from divorce orders, for medical bills. Whichever parent brings a minor child in for treatment will be responsible for payment of the fee (regardless of court orders.). There will be a \$35 charge for returned checks.

Refunds: Refunds resulting from a cash or check payment will be issued to you via a check at the end of the billing period. Credit card refunds will be processed via the same credit card used to make payment.

Forms Completion/ Medical Records Requests: From time to time various forms including but not limited to disability, and FMLA forms will be completed. There will be a \$10.00 fee per occurrence.

Missed/Cancelled Appointments: A fee of \$25 (per occurrence) will be charged to your account for missed appointments or appointments cancelled without giving the office at least 24 business hours' notice. Please note there is a separate fee schedule for cancelled procedures & surgeries. This policy will be discussed with you prior to scheduling.

Consent for Medical Treatment: I authorize physicians and personnel to render medical treatment and evaluation if needed for this appointment and all future appointments. I further authorize X-rays, injections, casting, or other diagnostic tests and treatments that may be necessary.

I have read and understand the payment policies set forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment of my account with Yale Podiatry Group and have provided to the best of my ability the information requested accurately and completely.

Signed (patient, parent or authorized individual)

Date

Acknowledgement of Receipt of Notice of Privacy Practices

PLEASE READ THIS ACKNOWLEDGMENT PRIOR TO SIGNING:

(Our notice of Privacy Practices is attached to our clipboards, displayed in the waiting area, & is also available on our website @ www.yalepodiatrygroup.com)

You May Refuse to Sign This Acknowledgment

I _____, have received a copy of Yale Podiatry Group's Notice of Privacy Practices.

Print Name

Signature

Date: _____

For Office Use, Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

MA Initials: _____

Stay Connected

For your convenience the following features are now available:

- **Request appointments online**
- Receive text message appointment reminders
- Refer your friends online
- Confirm appointments via email
- Submit patient satisfaction surveys
- **Access to patient portal**
 - Request a refill for a prescription prescribed by your podiatrist
 - Pay your bill online
- **Receive a summary of your visit**
 - **Secure Messaging**

Contact Preferences (Appointment Confirmations)

Home # _____

Cell # _____

- SMS (Turn on text message notifications)

Email: _____@_____

Allowed Telephone Contacts

- Patient only
- Patient and/or spouse
- Son/daughter
- Anyone answering the phone

Important Notice:

At any time, you may specify your email preferences using the link in the **welcome email** that will be provided to you. You may select features you wish to be subscribed to or you have the option to unsubscribe from all. Please keep in mind these are additional features in our office and you must notify a staff member of your preferences.

- Patient portal
 - Online bill pay
- Electronic summaries of your visit
 - Secure Messaging

Patient Information

Name _____
Address _____
City, State, Zip _____
Date of Birth ____/____/____ Social Security # _____
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow
Emergency Contact: Name _____
Relationship: _____ Contact #: _____
* Please write the <u>name</u> of your insurance below, you do not need to write the ID#, we will scan your cards. <input type="checkbox"/> Insurance (If you have insurance please complete the section below) <input type="checkbox"/> Self-Pay (No Insurance)
Employer: _____ City, State _____
NAME of Primary Insurance _____ Primary Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other
Subscriber Date of Birth ____/____/____ Subscriber #: _____
NAME of Secondary Insurance _____ Secondary Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other
Subscriber Date of Birth ____/____/____ Subscriber #: _____
*Responsible Party: (Name of person financially responsible for this account) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other
Name: _____
Contact #: _____ SS#: _____
*Primary Physician _____ City: _____ Phone#: _____
*Date you last visited your primary physician (Guarantees payment by your insurance company): ____/____/____
Referring Physician _____ City: _____ Phone#: _____
If you were not referred by a physician, how did you hear about us?
<input type="checkbox"/> Friend/Family _____ <input type="checkbox"/> Previous Patient <input type="checkbox"/> Internet Search <input type="checkbox"/> Social Media <input type="checkbox"/> Other

I authorize the release of my medical records & diagnosis to any third-party payers. I authorize payment of medical benefits to Yale Podiatry Group for services. I realize I am responsible for payment for services rendered to me. I authorize the disclosure of my medical history and/or diagnosis by my physician to health personnel when necessary for medical care. I permit a copy of this authorization to be used in place of the original.

Signature _____ Date _____

Past Medical History

*Reason for today's visit? _____ Duration: _____

Height: _____ ft _____ in Weight: _____ lbs Shoe Size: _____ Shoe Width: _____

Medications (If you have a list, you may bring to the front desk to be scanned)

Allergies: _____ If no known allergies please check

Past Surgical History: _____

Date of last Tetanus vacc. _____ Date of last Influenza vacc. _____ Date of last Pneumonia vacc. _____

Social History: Do you smoke? Yes No Previously Do you drink alcohol? No Yes, if so Daily Occasionally

Do you exercise? No Yes, if so what kind? _____ Weight change over the last 6 months? Gain Loss

Activity during work: Sit Stand Walk Have you fallen in the last year? No Yes, if so how many times? _____

Family History: Please check all that apply: M(Mother) F(Father) S(Sister) B(Brother)

Foot Problems: M F S B **Cancer:** M F S B **Diabetes:** M F S B

Hypertension: M F S B **Heart Disease:** M F S B **TB:** M F S B

Other (Explain): _____

HEENT: Dizziness Frequent Headaches Head Injury Seizures Sinusitis Difficulty: Vision Hearing

Other/Explain: _____

Cardiovascular: Angina Blood Clots Heart Attack Hypertension Palpitations Edema Claudication

Varicose Veins Irregular Heartbeat

Pacemaker: Yes No

Stent: Yes No

Other/Explain: _____

Orthopedics: Foot Problem Ankle Problems Knee Problems Hip Problems Back Problems

Other/Explain: _____

Hematologic: Blood Thinning Medication Easy Bruising Phlebitis Anemia Hepatitis

Other/Explain: _____

Respiratory: Asthma Bronchitis Chronic Cough Emphysema Shortness of Breath

Other/Explain: _____

Gastrointestinal: Colitis Inflammatory Bowel Disease Stomach Ulcer Reflux Hiatus Hernia

Other/Explain: _____

Genitourinary: Kidney Disease Hemodialysis Incontinence Prostate

Other/Explain: _____

Neuromuscular: Stroke Neuropathy Paralysis Contractures Sciatica Back Pain

Other/Explain: _____

Rheumatologic: Arthritis Joint Pain/Swelling Rheumatic Fever Scarlet Fever Lupus

Other/Explain: _____

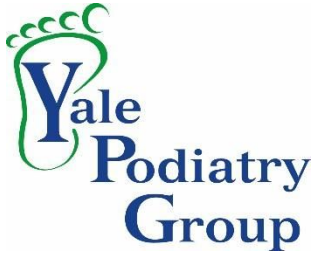
Endocrine: Diabetes- (Type I Type II- If so, last known A1C level: _____) Thyroid Pituitary

Other/Explain: _____

Integumentary: Skin Allergies Rashes Dermatitis Psoriasis Itching

Other/Explain: _____

OFFICE USE ONLY: BP: _____ P: _____ T: _____ R: _____ O: _____ MA's Initials: _____



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Pharmacy Preferences

Name of my Preferred Pharmacy: _____

Pharmacy Address: _____

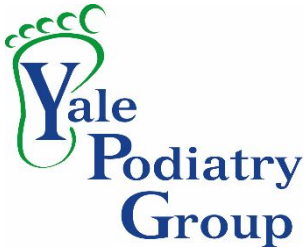
Pharmacy Phone #: _____

In the event you are prescribed a narcotic please acknowledge the following: This is just an acknowledgement, it does not mean you will be prescribed a narcotic.

I _____ understand that a narcotic **may be** prescribed to me as a part of my treatment plan by my podiatrist. I understand that this medication is to be taken exactly as prescribed and am not to share this medication with anyone. I understand that if my medication or my physical paper prescription for my medication is lost, damaged, or stolen I will not be given another prescription until the date after that one is complete. I understand that there are no exceptions to this policy. Furthermore, I understand it is my responsibility to inform my podiatrist of any allergies or intolerance I have experienced to any narcotics previously.

Patient Signature

Date: _____



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Medical Records Release

Date: _____

Doctor: _____

I am hereby requesting that the following medical records be released to Ansonia Podiatry Associates, LLC for evaluation required for the continuation of my care.

Medical Records:

- Recent Medication List
- Recent Lab Work
- Vaccination Record
- Last Encounter Chart Notes

Please fax to 203-734-8265

Patient Name: _____ DOB: _____

Signed _____