Yale Podiatry Group

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 as your health care provider. We are committed to the successful treatment of your condition. Payment of your bill is considered part of your treatment and a clear understanding of our financial policy is important to our professional relationship. **The front desk will instruct you which boxes you will need to read & initial, based upon your insurance. Thank you.**

	We will bill your insurance as a courtesy to you with a copy of your current insurance card. 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, full payment is due at the time of service. 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.	
	Medicare and Medicare Advantage: We accept Medicare assignment. You are responsible for your deductible, any coinsurance and the difference between the approved charge and the amount Medicare pays. If you have supplemental insurance, we will submit the claim for you. Any remaining balance will be billed to you.
	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.
	Workers Compensation: If you are here as a result of a work related injury, we will require information regarding both health insurance and your employer's Workers Compensation insurance. Your employer's human resource office should be able to assist you with obtaining this information. If payment is not received, the balance is your responsibility.
	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 on charges paid in full at time services are rendered. 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 will have to reschedule your appointment otherwise you may be responsible for payment.
	Delinquent Accounts: All balances are due within 30 days of your statement. Please read our billing policy carefully to make sure you choose the best billing option that works for you. 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) may be charged to your account for missed appointments or appointments cancelled without giving the office at least 24 hours' notice. Please note there is a separate fee schedule for cancelled procedures & surgeries. This policy will be discussed with you prior to scheduling either.	
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 ACKNOWLEDMENT 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: _____

Patient Information

Please read this packet in its entirety. Sections indicated with an * are required.

Name_____
(First) (Middle) (Last)

Address_____

City, State, Zip_____

Contact Info:
Home #: _____ Cell #: _____

*Email (Patient Portal \Online Bill Pay Access):
_____

Date of Birth_____/_____/_____Social Security #_____ Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Widow

Emergency Contact: Name_____

Relationship: _____**Contact #:** _____

***The following insurance section must be filled out.**

☐ Insurance (If you have insurance please complete the section below) ☐ Self-Pay (No Insurance)

Employer: _____City, State, Zip_____

NAME of Primary Insurance_____ Primary Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Subscriber Date of Birth____/____/____ Subscriber SS#: _____

NAME of Secondary Insurance_____ Secondary Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Subscriber Date of Birth____/____/____ Subscriber SS#: _____

Do you have any additional insurance? ☐ **No** ☐ **Yes** If yes, please complete the following:
NAME of Tertiary Insurance_____ Tertiary Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Subscriber Date of Birth____/____/____ Subscriber SS#: _____

***Responsible Party:** (Name of person financially responsible for this account) ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name_____
Contact #: _____ SS#: _____Relationship: _____

***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?

☐ Friend/Family_____ ☐ Previous Patient ☐ Internet ☐ Phonebook ☐ 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: _____

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 ☐ Pacemaker

☐ Varicose Veins ☐ Irregular Heart Beat ☐ Claudication *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

Endocrinologist (Doctor that manages your diabetes): _____

Other/Explain: _____

Integumentary: ☐Skin Allergies ☐Rashes ☐Dermatitis ☐Psoriasis ☐Itching

Other/Explain: _____

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

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Narcotic & Drug Policy

Date: _____

DOB: _____

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

Name of my Preferred Pharmacy: _____
Pharmacy Location: _____

Last Revised: 10/23/2015

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Ansonia, CT 06401

4 Corporate Drive Suite 384
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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 continuing 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_____

Patient Portal \ Online Bill Pay Information Handout

Via the patient portal you will be able to:

- View medication list and request refills on those prescribed by our office.
- View and print health summary.
- View balances and pay your bill conveniently online using a MC, Visa, Discover, or American Express.

The Patient Portal is *NOT* intended for the following:

- ***No*** diagnosis or treatment is offered by portal email. Diagnosis can only be made and treatment rendered after the patient schedules an appointment and is seen by a provider.
- ***No*** emergent communications or services.
- ***No*** request for narcotic pain medication will be accepted.
- ***No*** request for refill medication not currently being prescribed by one of our providers will be accepted.

Instructions to access your patient portal if you have not accessed already via our website.

1. You will receive your Patient Portal URL in an email. After receiving this message, click on the link in the email to go to our patient portal main page.
2. Once on the Patient Portal main page, click on the Register a New User link to begin the registration process.
3. On the Registration page, you must enter the below information:
    1. First Name
    2. Last Name
    3. Email Address
    4. Password
    5. Confirm Password
        1. Note: Passwords must be at least 6 characters in length.
4. Click Register. You will be taken to a page informing you to check your email to begin the two-step confirmation process.
5. Check the email you signed up with for an email from donotreply@traknetpm.com. Open this email and click the link contained therein to be taken to a page on the portal stating that your email is now confirmed.
    1. At this point, the second step of the confirmation process must begin: our office must approve your account.
6. Once we have approved your account, navigate back to the Patient Portal URL and log in with your email and password. You will be taken to a page that states Patient List, where you can begin listing patients on your user account.
7. To add a new patient, click on the Create New link. A demographics screen will open where you will need to enter all demographic information for your patient. Required fields are denoted with an *.
8. Once you have entered all information, click Save.
9. The next step is to update your Insurance information. From the Patient List, select the patient whose insurance information you would like to document by clicking the Select link, then click Insurance.
10. To document your insurance information, enter all required fields, denoted with an *, and click save.
11. Once you have documented your demographic and insurance information, you can send that information to us by clicking the Send button. This will allow us to add your information to our system before you arrive, streamlining the check in process.
12. After you visit our office, you can log back into your patient portal to review your allergies, medications, and review clinical information about your visit.

If you have any questions regarding your patient portal account, please contact Felicia @ 203-734-4806

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Surgical Consultation Questionnaire

Name: _____DOB:_____

Date of Last Physical: _____Where:_____

Date of Last Blood Work: _____ Where: _____

Primary Care Physician: _____

Cardiologist: _____

Have you had a recent EKG ☐No ☐ Yes (If Yes) Where: _____

Have you been to Griffin Hospital previously for treatments? ☐Yes ☐No

History of Infectious Diseases: ☐ MRSA ☐ VRE ☐ HEPATITIS ☐ OTHER_____

Are you diabetic? ☐Yes ☐No Are you taking aspirin? ☐Yes ☐No

Do you have an auto immune disorder? ☐Yes ☐No

Requested date of surgery (Tuesdays Only): _____

Billing Questions

Payment Information- The section below must be filled out.

☐ ***Commercial Insurance*** ☐ ***Medicare/Medicare Advantage Plan*** ☐ ***State (Title #19), Husky A, B, C, D***
☐ ***Self-Pay***

Primary Insurance: _____ID#_____

Do you have a deductible? _____If yes, how much have you used? _____
Max. Annual Benefit? _____

Secondary Insurance: _____ID#_____

Do you have a deductible? _____If yes, how much have you used? _____
Max. Annual Benefit? _____

I understand that Yale Podiatry Group will discuss my benefits with my insurance company for any procedure I may have. A deposit may be required prior to surgery depending on the allowed amount estimated by my insurance company.

Signature: _____ Date: _____

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Yale Podiatry Group

Surgeon: Dr. Luke Jeffries
Scheduled Surgery Date: _____

Pre-Op Instructions

1. Complete your scheduled testing (if applicable):_____

   _____

   _____

2. Mandatory Pre-Op Interview
   - Griffin Hospital will contact you for a pre-op interview the Friday prior to your surgery.
   - _____
3. Any questions please call Marcia @ 203-734-4806

Post-Op Instructions
Please read thoroughly.

1. Please have your prescription filled immediately, and take only as directed.
2. Keep off of your feet as instructed for the first few days following your surgery, **only bathroom privileges are acceptable.**
3. **Keep your foot elevated above heart level** by placing one or two pillows under it from the back of your knee. Your foot should be kept on top of any blankets.
4. Place an ice bag on top of your foot for the first 48 hours following surgery. The ice bag should be removed for one hour, every four hours. **Do not use the ice at night.**
5. **You must not get your bandage wet or soiled.** Please call the office if this occurs.
6. **You must not walk without wearing your surgical shoe and you may never drive while wearing the surgical shoe, as this can result in a serious injury.**
7. Please call the office tomorrow morning to schedule a follow-up appointment and let us know your progress.

Should you have any undue discomfort, swelling, or bleeding the doctor can be reached at the

Office: 203-734-4806 or Cellphone: 203-360-2081

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