MICHAEL FRANK D.P.M., MARC GOLDBERG D.P.M, ADAM LOWY D.P.M., SCOTT NUTTER D.P.M.

10801 Lockwood Dr. Ste 260 Silver Spring, MD 20901 301-439-0300
13950 Baltimore Ave. Laurel, MD 20707 301-317-6800
3720 Farragut Ave, Ste 303 Kensington, MD 20895 301-942-8110
3408 Olandwood Court, Ste 204 Olney, MD 20832 301-924-5044
5801 Allentown Road, Ste 305 Camp Springs, MD 20746 301-868-7670
10981 Johns Hopkins Rd., Unit 210 Laurel 20723 301-317-6800

PATIENT INFORMATION

Date_____

SS/HIC/Patient ID #_____

Patient Name_____
Last Name

_____
First Name Middle Initial

Address_____

City_____

State_____Zip _____

E-mail _____

Sex ☐ M ☐ F Age_____Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for_____years

Patient Employer / School _____

Employer / School Address _____

_____

Employer / School Phone (_____) _____

Spouse's Name _____

Birthdate_____SS# _____

Spouses Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (____)_____

Cell Phone (____)_____

Best time and place to reach you_____

IN CASE OF EMERGENCY CONTACT

Name_____

Relationship_____

Home Phone (____)_____

Work Phone (____)_____

INSURANCE

Who is responsible for this account?_____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate_____SS#_____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Drs. Michael Frank, Marc Goldberg, Adam Lowy, and Scott Nutter all insurance benefits, if any, otherwise payable to me or services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies)and their agents for the purpose of obtaining payment for servicesand determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE /MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Drs. Frank, Goldberg, Lowy, and Nutter for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits for benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____

_____ _____
Date Relationship to Beneficiary

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints)

_____
_____
_____
_____
_____

Have you ever been to a Podiatrist before?

☐ Yes ☐ No

If Yes, please list:

Name_____

Last Visit_____

Is there any personal or family history of diabetes?

☐ Yes ☐ No

Your Occupation_____

Cigarette/ Tobacco use _____

Years smoked _____

Athletic activities in which you participate (please list and indicate frequency)

_____
_____
_____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Calluses	☐ Yes	☐ No
Cramps or Numbness in Feet/Legs	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Swelling in Ankles or Feet	☐ Yes	☐ No
Tired Feet	☐ Yes	☐ No

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Ear Problems	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No
Allergies to Anesthetics	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Allergies to Medicine or Drugs	☐ Yes	☐ No	Eye Problems	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Foot or Leg Cramps	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Heart Valves or Joints	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Hepatitis or Jaundice	☐ Yes	☐ No	Swelling in Ankles, Feet	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tired Feet	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Neuropathy	☐ Yes	☐ No	Weight Loss, Unexplained	☐ Yes	☐ No

Height_____ Weight: _____ HgbA1c_____

Surgeries you have had: _____

_____

Hospitalization other than for the surgeries listed: _____

_____

_____

Primary Care Doctor _____ Last Visit Date:_____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

_____

_____

Pharmacy _____

Pharmacy Phone (____)_____

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

☐ Adhesive/ Tape	☐ Ibuprofen
☐ Anticoagulant Therapy	☐ Local Anesthetics
☐ Aspirin	☐ Penicillin
☐ Codeine	☐ Seafoods
☐ Demerol	☐ Sulfa Drugs
☐ Iodine	☐ Latex

Other _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary

_____ _____

Signature of Patient, Guardian, or Personal Representative Date

_____ _____

Please print name of Patient, Guardian, or Personal Representative Relationship to Patient

Medication List

If your list of medications doesn't fit on the New Patient paperwork feel free to use this form

Name:_____

Medications List		
Please list all Meds. Vitamins and Supplements		
Medication	**Dosage**	**Frequency**

Current Height:_____ Current Weight:_____

_____ _____

Patient Signature Date

FINANCIAL POLICY FOR FAMILY FOOT AND ANKLE ASSOCIATES OF MARYLAND, P.A.

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service if there is no secondary insurance.

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.

COPAYMENTS AND DEDUCTIBLES: All co-payments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

24 HOUR CANCELLATION POLICY: I understand that Family Foot & Ankle Associates of Maryland, P.A. will bill me for appointments missed or not canceled with at least 24 hours' notice.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

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. As a result, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 31% of the debt, and all cost, and expenses, including reasonable attorneys' fees, we incur in such collection efforts. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA, MasterCard, and Discover. An additional $35.00 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.

I have read the above policy regarding my *financial responsibility* to Family Foot & Ankle Associates of Maryland, P.A. for medical services provided. I agree to pay Family Foot & Ankle Associates of Maryland, P.A. any balance unpaid by my insurance carrier for myself or the below named person.

ASSIGNMENT OF BENEFITS: I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Family Foot & Ankle Associates of Maryland, P.A.** All insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

PRINT Patient Name: _____
Signature:_____

FINANCIALLY RESPONSIBLE PARTY:
PRINT Name: _____
Signature: _____

Relationship to Patient: _____ Date: _____

PATIENT HIPAA ACKNOWLEGEMENT AND DESIGNATION DISCLOSURE FORM

FAMILY FOOT & ANKLE ASSOCIATES OF MARYLAND, P.A.

I. 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 and that I have read (or had the opportunity to read if I so chose) and understood the Notice of Privacy Practices and agree to its terms.

_____

Patients Name (please print)

_____

Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

II. Acceptable Means of Communications:

I give Family Foot & Ankle Associates of Maryland, P.A. permission for the doctor's and/or staff to leave messages for me at home, work, or cell phone as needed regarding appointments, billing, or any other information regarded as necessary.

Exclusion: ( ) NONE or _____

_____ _____

Signature Date