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DIPLOMATES, AMERICAN BOARD OF PODIATRIC SURGERY
FELLOWS, AMERICAN COLLEGE OF FOOT AND ANKLE SURGEONS

WELCOME TO OUR OFFICE

We are pleased that you have chosen us to provide care for your foot problem and look forward to having you as our patient. The initial evaluation will encompass a complete history and evaluation of your complaint. We will then discuss your problem and the various treatment regimens. No matter how much time is spent on your examination, every effort will be made to relieve you of any discomfort on this initial visit. Please complete the following forms and answer each question so that we may provide you with the optimal care.

In order to minimize billing costs we request payment at the time of service, unless you are a member of an insurance plan with which this office participates in. Please provide our office staff with all insurance documentation for each plan you are covered under. Please do not hesitate to inquire about any fee or service related to your care.

Patient:

First Name: ____________________________ Last Name: __________________________Date of Birth:____/_____/____ Age:_____

Address:____Apt#:________City:________________State:__________Zip:_______________

Home#:___________________________________Cell#:___________________________________Email: _______________________________

Sex: M F Marital Status S M W D Social Security #:_________ -__________ - ______________

Employer Name:______________________________________ Occupation:____

Employer Address:____________________________ City: ____________________________State: _________ Zip: ___________________

Work #:____Extension: ___________________

Emergency Contact: ___________________________Phone #: ______________________Relationship to patient:________________

Insurance Information:

Primary Insurance: ___________________________________ID#: ___________________________Group#:__________________________

Name of Policy Holder: ____________________________Date of Birth: ____/___/____ Relationship to Patient: ____________

Secondary Insurance: _________________________________ ID#:___________________________ Group #: ________________________

Name of Policy Holder: ____________________________Date of Birth: ___/____/____ Relationship to Patient:______________

Is This A Work Related Injury? Yes or No If yes, date of Accident: _______/_____/____ Claim#: ________________

Adjustor: __________________________________ Phone#:________________________________

Medical Information:

Primary Care Physician: _______________________________ Date Last Seen:__________ Tel#:________________________

Address:____City: _____________________________ State:______ Zip: _____________

Pharmacy Name: ____Phone#: _______________________________Zip:_____________

Whom May We Thank For Referring You To This Office?

Doctor: ____ Phone#:__________________________

Friend/Patient:_________________________________

Please Answer All Questions

Please describe your foot problem(s): ____

How long has it bothered you?: ____

Previous treatment of any foot problem:____

Previous Operations: ____

Have you been treated or suffer from any of the following?

ILLNESS	YES	NO	COMMENTS
Diabetes			
High Blood Pressure			
Heart Disease			
Stroke			
Asthma/ Breathing			
Kidney/Bladder			
Liver/Hepatitis			
Arthritis			
Ulcer/Digestive			
Poor Circulation			
Bleeding Disorder			
Blood Transfusion			
Neurologic Disorder			
Cancer			
Thyroid			
Sexually Transmitted Disease			
Substance Abuse			
Allergies			
Smoke			

List All Medicines YouAre Currently Taking: (Please fill out medications, dosages prescribed with and how many times a day. Also include Herbs, Vitamins, Minerals, and any other Supplements).

Medication	Dosage	# Times a day	Reason for medication (e.g. High Blood Pressure)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Patient Signature:____ **Date:**_________________________

DR.TREPAL & JULES DPM

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff.

- **As our patient, you are responsible for all 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 either : Cash, Check, Credit or Debit Cards**

- **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 doctors. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, you will receive a bill.**
- **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 services or referrals; however you remain responsible for charges to any services 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 authorizations/referral requirements, in the event the office is not informed, you will be responsible for any charges denied.**
- **There are certain elective surgical procedures for which 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 or at the time of your pre-op appointment.**
- **Patients who are 90 days past due on their balance will be sent to collections, unless a payment plan has been put into place.**
- **There is a service fee of $25.00 for all return checks. Your insurance company does not cover this fee.**
- **In fairness to all of our patients, we understand that emergencies occur, but no shows or cancellations with less than 24 hours notice will result in a fee of $50.00.**

Signature of Patient / Responsible Party: ________________________________ Date: _________________

Printed Name of Patient/ Responsible Party: ____

ACKNOWLEGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

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.

____ ____________________________

Patient Name (Please Print) **Date**

____

Parent or Authorized Representative (If applicable)

____

Signature