Lake Washington Foot and Ankle

Dr. Robert P. Dunne

(321)253-6191

Please fill out completely or mark areas "n/a" if they do not apply

Name:_____Birth Date:_____Sex: M/F

Social Security Number: _____Marital Status:_____

Address:_____

Reside Year Round: Y/N Alternate Address: _____

Cell Phone: _____Home Phone: _____Work Phone: _____

Email Address:

_____

Emergency Contact:

_____Relationship:_____

Emergency Contact Phone Numbers: _____

Primary Care Doctor:_____ Phone Number: _____

Who May We Thank For Referring you? :_____

May We Contact/Send Records To Your Primary Care Doctor Or Referring Doctor? : Y/N

Insurance: please give all cards with photo ID to the receptionist so we may copy them into your chart

Primary Insurance: _____Policy ID:_____

Secondary Insurance: _____Policy ID:_____

Tertiary Insurance: _____Policy ID:_____

Who Is Your Policy Holder?

Name: _____SS#:_____DOB:_

Address: _____

Relationship To Patient: _____Primary Phone Number: _____

I certify that the above information is current and accurate. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions. LWFAC and its representatives may use my health care information and may disclose such information to the above-named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services received.

Print Name:_____ Signature: _____Date: _____

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Assignments Of Benefits Form:

Name:_____Birth Date:_____Todays date: _____

Retired/ Employed—Place Of Employment:_____

Member/Policy ID :_____

Insured's SS#:_____

I Hereby Instruct And Direct (Insurance companies name):_____
To Pay By Check Made Out To And Mailed To:

Robert P. Dunne, D.P.M, P.A

2717 North Wickham Rd. ST 4

Melbourne, FL 32935

~OR~

If My Current Policy Prohibits Direct Payments To The Doctor, I Herby Instruct You (The Insurance Company) To Make Out The Check To Me and Mail it As Follows:

Your Name:_____

C/O Robert P. Dunne, D.P.M, P.A

2717 North Wickham Rd. ST 4

Melbourne, FL 32935

For the professional or medical expense benefits, allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE POLICY. This payment will not exceed my indebtness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____

Signature of Patient Or Guardian of Patient Date

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Office Financial Policy:

Welcome to our podiatry family, we are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, Mastercard, Visa, Discover, or American Express. We will be happy to help you process your insurance claim-form. We are NOT a Medicaid provider and cannot file ANY Medicaid claims. Dr. Dunne is a POS/PPO/EPO provider to most insurance companies; however he is not an HMO provider with the exception of Medicare, Aetna, and HealthFirst. Your out of network benefits may apply if applicable. **If you require an authorization or referral for your appointment, it will be your responsibility to obtain on from your primary care doctor or insurance company.** Filing your insurance for you does not guarantee payment, and a sum remaining after your insurance makes payment may result in a balance. This may be called a coinsurance or deductible and would be in addition to any copayment made at the time of service. Please be aware that many insurance companies are charging separate copays or coinsurance for imaging or additional services such as X-rays, Ultrasounds, Injections, as well as some in office procedures.

You are welcome at anytime to copies of your medical records as well as x-rays. We do ask for at least 72 hours notice to prepare these for you. There is a standard fee for copies of x-rays of $10.00 per sheet an this is to offset the cost of duplicating the films. If you have the need for disability, FMLA, or other paperwork to be completed, this carries a $20.00 fee per occurrence. **Returned checks incur a fee of $25.00.**

You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company
2. Our fees are generally considered to fall within the acceptable range by most insurance companies, and therefore are covered up to maximum allowance determined by each carrier, which is defined as usual customary, and reasonable. Not all services are a covered benefit. Some insurance companies arbitrarily select certain services they will not cover.
3. Durable medical equipment and other supplies authorized by the insurance company for the office are still subject to medical review when received at your insurance company. Authorization does not guarantee payment. If these services are denied, you will be responsible for payment to the provider.

A $25.00 fee will be assessed to your account if you do not notify us within 24 hours of your cancelled appointment.

Just a reminder that when this account is placed with our collection agency their fee of 35% will be added to the total amount due.

We must emphasize that, as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us, we are here to help!

_____ _____

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Patient Consent Form:

The department of health and human services has established a "privacy rule" to help insure that personal health care information is protected for privacy. The privacy rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or heath care operations.

As our patients we want you to know that we respect the privacy of your personal medical records and will do all that we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatments, payments or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice. If you have any obligations to this for, please ask to speak with our HIPPA compliance officer.

_____ _____

Signature of Patient Or Guardian of Patient Date

Name:	Relationship:

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Medical History

Name:_____Date:_____

Chief Complaint:

_____

_____

Family History:

Diabetes __Mother __Father
Heart Problems __Mother __Father
High blood pressure __Mother __Father
Foot problems __Mother __Father
Cancer __Mother __Father
Deceased __Mother __Father

Medical History: Please circle all that apply

Heart Problems
Pace Maker
Arthritis
Blood Clots
Lung Problems
Cholesterol
Diabetes ___I or___II
Thyroid___Hypo or __Hyper
High___ or Low___ Blood pressure
Back pain
Bleeding Tendencies
HIV
Muscle Weakness
Hepatitis
Asthma
Stomach Problems
Neurological disorders
Kidney Problems
Cancer:_____

Other Medical history not listed above:

_____

_____

All surgical history even if unrelated to the foot:

_____

_____

Medication allergies:

_____

_____

Social History:

Smoker: Present, Former or Never
Pregnant: ___ Yes or ___No
Sleep: well___Or ___Diagnosed Sleep apnea
Weight: _____
Alcohol: ___Yes or ___ Never
Exercise: ___ Yes or ___No
Height:_____
Shoe size:_____

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Patient Name: ____Date Of Birth: ______________________

Name Of Medication	**Dosage**	**Frequency**