ADVANCED FOOT CARE, INC.
PAULA M. MARELLA, DPM FACFAS
95 TREMONT ST
DUXBURY, MA 02332
Phone: 781-934-8447 **Fax: 781-934-8446**

Thank you for choosing our practice for your healthcare needs. This letter contains information to help prepare you for your visit.

Enclosed is your new patient packet. Please complete the new patient packet and bring with you to the office at 95 Tremont St., Suite 5, Duxbury, MA 02332.

Before your appointment:

1. Ensure that you have Dr. Paula Marella (NPI# 1144327214) to obtain your Insurance referral if needed by your primary care physician. If you do not obtain one prior to your appointment it will result into rescheduling the appointment.
2. If you have any X-rays (disc) or reports, please bring them with you the day of your appointment.

Day of your appointment:

1. Please arrive 15 minutes, to allow time for registration. Failure to do so may result in rescheduling your appointment.

2. Bring with you:
   a. Photo ID
   b. Your insurance card(s)
   c. Co-payment if required by your insurance in cash, check or charge
   d. Complete medication list, dosages and directions. Include over the counter (OTC) medications. If you are currently taking any prescription medications.

If you have any questions, please call our office
781-934-8447
We are closed for lunch daily 12-1pm

We kindly request 24-hour notice to cancel or change an appointment. No phone call may result in a no-show.

We look forward to meeting you and providing you with care at **Advanced Foot Care, Inc.**

ADVANCED FOOT CARE, INC.

PAULA M. MARELLA, DPM, FACFAS KIMBERLY T. THURMOND DPM, CWS

REGISTRATION INFORMATION

LASTNAME:	FIRST NAME:	MI

SOCIAL SEC.#:	DATE OF BIRTH:	AGE:	SEX:

MAILING ADDRESS:

CITY:	STATE:	ZIP CODE:	EMAIL:

HOME PHONE:	CELL PHONE:

PREFERRED METHOD OF VERBAL COMMUNICATION (PLEASE CIRCLE ONE): HOME PHONE CELL PHONE	MAY WE LEAVE A MESSAGE? YES NO

RACE:	ETHNICITY: HISPANIC NON-HISPANIC OTHER	MARITAL STATUS:

PRIMARY CARE PHYSICIAN:

NAME

ADDRESS

PHONE:

CARE PLAN:

**DO YOU HAVE A SURROGATE DECISION MAKER: NO ____ YES ____

NAME:

PHONE: RELATIONSHIP

EMERGENCY CONTACT:

NAME:

PHONE: RELATIONSHIP:

PHARMACY NAME (LOCAL)

NAME OF PHARMACY:

ADDRESS:

CITY: STATE: ZIP CODE:

INSURANCE

PLEASE GIVE CARDS TO RECEPTIONIST

INSURANCE PLAN 1 SUBSCRIBER ID:

INSURANCE PLAN 2 SUBSCRIBER ID:

I, THE UNDERSIGNED, AUTHORIZE ADVANCED FOOT CARE TO EXAMINE AND TREAT MY FEET AND ANKLES MEDICALLY, SURGICALLY, OR BIOMECHANICALLY. I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO ADVANCED FOOT CARE AND I AM RESPONSIBLE FOR ANY UNPAID BALANCE. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ALL CLAIMS.

SIGNATURE (PATIENT OR GUARDIAN):_____DATE:_____

NAME_____DOB_____

MEDICAL HISTORY

BRIEFLY DESCRIBE THE REASON FOR TODAY'S VISIT: _____

ONSET OF SYMPTOMS: _____

PREVIOUS TREATMENTS: _____

ANY IMAGING FOR TODAY'S PROBLEM? _____

PAST MEDICAL HISTORY: **CIRCLE ALL THAT APPLY**

ASTHMA	COPD	DIABETES TYPE I OR TYPE 2
ATRIAL FIBULATION	DVT/PE	FIBROMYALGIA
AUTOIMMUNE DISEASE	GOUT	NEUROPATHY
TYPE:	HEART DISEASE	PERIPHERAL VASCUALR DISEASE
BLEEDING DISORDER	HIV	HIGH BLOOD PRESSURE
HIGH CHOLESTEROL	CANCER	HEPATITIS OTHER

HEIGHT:_____ **WEIGHT:**_____ **SHOE SIZE:**_____

MEDICATIONS: WHAT MEDICATIONS ARE YOU TAKING?

_____ _____ _____

_____ _____ _____

DO YOU GIVE PERMISSION TO ACCESS YOUR PRESCRIPTION HISTORY? YES NO

ALLERGIES: **NONE**

_____ _____ _____ _____ _____ _____

PAST SURGICAL HISTORY: JOINT REPLACEMENT FOOT/ANKLE

SPINE/CERVICAL OTHER

SOCIAL HISTORY: **SMOKE: YES: AMOUNT**_____**/DAY** **NO: QUIT NEVER**

ALCOHOL: NO YES AMOUNT/WEEK: _____

EXERCISE: NO YES TYPE/AMOUNT/WEEK: _____

FAMILY HISTORY: _____ _____ _____

I CERTIFY TO THE BEST OF MY ABILITY THAT THE INFORMATION IS TRUE AND ACCURATE AND THAT I HAVE DISCLOSED ALL PERTINENT MEDICAL HISTORY.

SIGNITURE OF PATIENT/GUARDIAN: _____ DATE: _____

ADVANCED FOOT CARE, INC
95 TREMONT ST, DUXBURY, MA 02332

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____ DOB: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

PURPOSE OF CONSENT: BY SIGNING THIS FORM, YOU WILL CONSENT TO OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS.

NOTICE OF PRIVACY PRACTICES: YOU HAVE THE RIGHT TO READ OUR NOTICE OF PRIVACY PRACTICES BEFORE YOU DECIDE WHETHER TO SIGN THIS CONSENT. OUR NOTICE PROVIDES A DESCRIPTION OF TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS, OF THE USES AND DISCLOSURES WE MAY MAKE OF YOUR PROTECTED HEALTH INFORMATION, AND OF OTHER IMPORTANT MATTERS ABOUT YOUR PROTECTED HEALTH INFORMATION.

WE RESERVE THE RIGHT TO CHANGE OUR PRIVACY PRACTICES AS DESCRIBED IN OUR NOTICE OF PRIVACY PRACTICES. IF WE CHANGE OUR PRIVACY PRACTICES, WE WILL ISSUE A REVISED NOTICE OF PRIVACY PRACTICES, WHICH WILL CONTAIN THE CHANGES. THESE CHANGES MAY APPLY TO ANY OF YOUR PROTECTED HEALTH INFORMATION THAT WE MAINTAIN.

RIGHT TO REVOKE: YOU HAVE THE RIGHT TO REVOKE THE CONSENT AT ANY TIME BY GIVING US WRITTEN NOTICE OF YOUR REVOCATION SUBMITTED TO ADVANCED FOOT CARE, INC. PLEASE UNDERSTAND THAT REVOCATION OF THIS CONSENT WILL NOT AFFECT ANY ACTION WE TOOK IN RELIANCE ON THIS CONSENT BEFORE WE RECEIVED YOUR REVOCATION, AND THAT WE MAY DECLINE TO TREAT YOU OR CONTINUE TO TREAT YOU IF YOU REVOKE THIS CONSENT.

SECTION C: HIPPA ACKNOWLEDGEMENT AND RECEIPT OF NOTICE OF PRIVACY PRACTICES.

PURPOSE: BY SIGNING THIS FORM, YOU ACKNOWLEDGE THAT YOU HAVE BEEN SHOWN THE PRIVACY POLICY FOR THIS OFFICE, AND YOU HAVE BEEN OFFERED A COPY OF SUCH POLICY TO KEEP FOR YOUR RECORDS.

I HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS CONSENT FORM AND I UNDERSTAND THAT, BY SIGNING THIS CONSENT FORM, I AM GIVING MY CONSENT TO USE AND DISCLOSE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES, AND HEALTH CARE OPERATIONS

SIGNATURE: _____ DATE_____

ADVANCED FOOT CARE, INC.
95 TREMONT ST, DUXBURY MA 02332
PATIENT RESPONSIBILITIES — PLEASE READ AND SIGN

- REFERRALS/PRIOR APPROVALS (IF APPLICABLE): I UNDERSTAND MY INSURANCE COMPANY WILL NOT REIMBURSE FOR THE COST OF TODAY'S SERVICES WITHOUT A REFERRAL/ PRIOR APPROVAL. I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT OF THE OFFICE CHARGE OR ANY OTHER CHARGES I MAY INCUR WITHOUT A REFERRAL/PRIOR APPROVAL.
- COPAY (IF APPLICABLE): I UNDERSTAND I AM RESPONSIBLE TO PAY A COPAYMENT FOR EACH VISIT. I UNDERSTAND THIS IS AN AGREEMENT I HAVE WITH MY INSURANCE COMPANY. I UNDERSTAND THAT MY COPAY IS DUE AT THE TIME OF EACH VISIT.
- DEDUCTIBLE (IF APPLICABLE): I UNDERSTAND THAT I HAVE A CALENDAR YEAR DEDUCTIBLE AS OUTLINED IN MY INSURANCE POLICY. I UNDERSTAND I AM RESPONSIBLE FOR THE PAYMENT OF ANY BALANCE THAT HAS BEEN APPLIED TO MY DEDUCTIBLE BY MY INSURANCE COMPANY.
- CO-INSURANCE (IF APPLICABLE): I UNDERSTAND THAT I HAVE A CO-INSURANCE RESPONSIBILITY AS OUTLINED IN MY INSURANCE POLICY. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ANY CO-INSURANCE BALANCE ASSESSED BY MY INSURANCE COMPANY.
- AUTHORIZATION TO PAY BENEFITS TO THE PROVIDER: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER FOR MEDICAL BENEFITS. I ALSO AUTHORIZE ADVANCED FOOT CARE, INC. TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIM.
- TERMINATION OF INSURANCE (IF APPLICABLE): I UNDERSTAND THAT IN THE EVENT MY INSURANCE POLICY IS TERMINATED OR CANCELLED, I AM RESPONSIBLE FOR ANY AND ALL CHARGES INCURRED AFTER THE TERMINATION/CANCELLATION. I UNDERSTAND IT IS MY RESPONSIBILITY TO NOTIFY THE OFFICE OF ANY CHANGES IN INSURANCE COVERAGE OR LAPSE OF INSURANCE BENEFITS DURING TREATMENT. IN THE EVENT THERE IS A CHANGE/LAPSE IN BENEFITS, I UNDERSTAND THAT IT WILL BE MY RESPONSIBILITY FOR PAYMENT OF NON-COVERED SERVICES.
- MOTOR VEHICLE INFORMATION (IF APPLICABLE): I UNDERSTAND IT IS MY RESPONSIBILITY TO PROVIDE AIL CLAIM INFORMATION ASSOCIATED MY MOTOR VEHICLE ACCIDENT AT THE TIME OF THE INITIAL VISIT. I REALIZE THAT WITHOUT THIS INFORMATION, I AM RESPONSIBLE FOR ANY CHARGES INCURRED AT THE TIME OF THE VISIT. I UNDERSTAND THAT MY HEALTH INSURANCE INFORMATION WILL BE PROVIDED AND BENEFITS UTILIZED IN THE EVENT MY PIP IS EXHAUSTED.
- WORKERS' COMPENSATION INFORMATION (IF APPLICABLE): I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PROVIDE ALL WORKERS' COMPENSATION BILLING INFORMATION PRIOR TO THE TIME OF THE INITIAL VISIT. I REALIZE THAT WITHOUT THIS INFORMATION, I AM RESPONSIBLE FOR ANY CHARGES INCURRED AT THE TIME OF THE VISIT. I UNDERSTAND THAT MY HEALTH INSURANCE INFORMATION WILL BE PROVIDED AND BENEFITS WILL BE UTILIZED IN THE EVENT THAT MY WORKERS' COMPENSATION CLAIM IS DENIED.

- CANCELLATION/NO SHOW: IF YOU ARE UNABLE TO KEEP A SCHEDULED APPOINTMENT, YOU MUST CONTACT THE OFFICE AT LEAST 24 HOURS IN ADVANCE. IF YOU FAIL TO NOTIFY THE OFFICE OF YOUR CANCELLATION WITH 24 HOURS, AND MISS YOUR SCHEDULED APPOINTMENT, A $30.00 FEE FOR THE APPOINTMENT YOU MISSED OR CANCELLED MAY BE CHARGED. THREE (3) MISSED APPOINTMENTS- THEY NEED NOT BE CONSECUTIVE — CAN RESULT IN DISCHARGE FROM THE PRACTICE. I HAVE READ, UNDERSTAND AND AGREE TO ALL OF THE PRECEDING INFORMATION.

SIGNATURE: _____ DATE: _____