Welcome to the Practice!

Please complete the attached forms. Bring these along with a copy of both sides of your insurance cards to the upcoming appointment. If your insurance requires a referral, please call your Primary Care Physician and make sure one is in place prior to the appointment.

We look forward to meeting you.

Thank you,

The Staff at Advanced Foot Care, Inc.

Appointment:

Time:

COVID Office Safety Precautions:

Do not come into the office if you are experiencing any flu like symptoms such as fever, cough, shortness of breath, chills, headache or sore throat.

A facemask or covering is required at all times while in the office.

Only patients, or patients plus one critical caregiver, are allowed into an appointment. All others please wait outside.

Please practice social distancing at all times in the office. We ask that you wait outside or in your car after checking in. We will call or text you at the time of your appointment.

Thank you for your cooperation.

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 NAME: 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: (print) _____ Date of Birth: _____

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 all 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: _____

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	OTHER
CANCER TYPE	HEPATITIS A OR B OR C	

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: _____