364 East Main Street
Ansonia, CT 06401

4 Corporate Drive Suite 384
Shelton, CT 06484

P: 203-734-4806

Email: office@yalepodiatrygroup.com

Thank you for choosing Yale Podiatry Group, please read this packet in its entirety.

We will bill your insurance as a courtesy to you with a copy of the insurance card you provide. All primary and secondary insurance information must be provided at time of service; you are responsible to notify our office of any changes to your insurance throughout the year. If the insurance information that you provide is incorrect, it will be your responsibility to guarantee payment. If you do not have your insurance card, we will reschedule your appointment when you have this information available. It is your responsibility to keep track of requirements of your plan. Each plan has different stipulations regarding how often services may be rendered and, more importantly, where those services may be performed. If you do not inform us of any special requirement in your contract and we subsequently order services, such as lab work or hospitalization, that are not covered, the selected medical facility will have no choice but to bill you for those charges. Payment for those charges is then your responsibility.

**UCR (usual, customary, and reasonable) Fees:** We are committed to providing the best treatment possible and we charge what is usual and customary for our area. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance company's arbitrary determination of UCR fees.

**Workers Compensation: STOP!** If you are here because of a work-related injury, please notify the front desk. Additional paperwork is required.

**HMO/PPO/Commercial:** All co-payments are due at the time of service no exceptions, we are participating physicians with most, but not all plans. You are responsible for verifying what your insurance plan will cover and that we are providers for your plan. You are responsible for any co-insurance and deductible.

**Medicare and Medicare Advantage:** We accept Medicare assignment. If you have supplemental insurance, we will submit the claim for you. If you do not have a secondary insurance, your deductible or coinsurance will be due at time of service.

**Self-Pay:** A minimum deposit of $200 or the actual charge, whichever is less, is due at the time of service. Currently Yale Podiatry Group offers a 20% prompt pay discount for charges that are paid in full. Any subsequent visit charges will be due at time of service. If you cannot pay in full, you will need to set up and adhere to a payment plan with our billing department. We accept Visa, MasterCard, American Express, Discover, cash and checks with a valid driver's license.

**Insurance Referrals:** Referrals are your responsibility to obtain prior to your visit, if required. If no referral is obtained prior to your visit we must reschedule your appointment otherwise, you may be responsible for payment.

**Delinquent Accounts:** All balances are to be paid in full within 30 days of your statement date otherwise you will be charged a $10.00 late fee. Unpaid balances with be transferred to Atlantic Collection Agency after 90+ days, unless an autopay payment arrangement is in place. We will not be involved in negotiating payment, from divorce orders, for medical bills. Whichever parent brings a minor child in for treatment will be responsible for payment of the fee (regardless of court orders.). There will be a $35 charge for returned checks.

**Refunds:** Refunds resulting from a cash or check payment will be issued to you via a check at the end of the billing period. Credit card refunds will be processed via the same credit card used to make payment.

**Forms Completion/ Medical Records Requests:** From time to time various forms including but not limited to disability, and FMLA forms will be completed. There will be a $10.00 fee per occurrence.

**Missed\Cancelled Appointments:** A fee of $25 (per occurrence) will be charged to your account for missed appointments or appointments cancelled without giving the office at least 24 business hours' notice. Please note there is a separate fee schedule for cancelled procedures & surgeries. This policy will be discussed with you prior to scheduling.

**Consent for Medical Treatment:** I authorize physicians and personnel to render medical treatment and evaluation if needed for this appointment and all future appointments. I further authorize X-rays, injections, casting, or other diagnostic tests and treatments that may be necessary.

**I have read and understand the payment policies set forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment of my account with Yale Podiatry Group and have provided to the best of my ability the information requested accurately and completely.**

_____

Signed (patient, parent or authorized individual) Date

## Acknowledgement of Receipt of Notice of Privacy Practices

**PLEASE READ THIS ACKNOWLEDGMENT PRIOR TO SIGNING:**
**(Our notice of Privacy Practices is attached to our clipboards, displayed in the waiting area, & is also available on our website @ www.yalepodiatrygroup.com)**

You May Refuse to Sign This Acknowledgment

I _____, have received a copy of Yale Podiatry Group's Notice of Privacy Practices.

_____ _____

Print Name Signature

Date: _____

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**For Office Use, Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

MA Initials: _____

## Stay Connected

**For your convenience the following features are now available:**

- **Request appointments online**
- Receive text message appointment reminders
- Refer your friends online
- Confirm appointments via email
- Submit patient satisfaction surveys
- **Access to patient portal**
    - Request a refill for a prescription prescribed by your podiatrist
    - Pay your bill online
- **Receive a summary of your visit**
    - Secure Messaging

**Contact Preferences (Appointment Confirmations)**

**Allowed Telephone Contacts**

- ☐ Patient only
- ☐ Patient and/or spouse
- ☐ Son/daughter
- ☐ Anyone answering the phone

Home # _____

# _____

Cell #_____

☐ SMS (Turn on text message notifications)

Email: _____@_____

# Important Notice:

At any time, you may specify your email preferences using the link in the **welcome email** that will be provided to you. You may select features you wish to be subscribed to or you have the option to unsubscribe from all. Please keep in mind these are additional features in our office and you must notify a staff member of your preferences.

- Patient portal
    - Online bill pay
- Electronic summaries of your visit
    - Secure Messaging

# Patient Information

Patient Name_____

Address_____

City, State, Zip_____

Date of Birth_____/_____/_____ Social Security #_____
Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Widow

Emergency Contact: Name_____

Relationship:_____Contact #:_____

* **Please write the name of your insurance below, you do not need to write the ID#, we will scan your cards.**
☐ Insurance (If you have insurance please complete the section below) ☐ Self-Pay (No Insurance)
Employer:_____City, State_____

**NAME** of Primary Insurance_____Primary Subscriber ☐Self ☐Spouse ☐Parent ☐ Other

Subscriber Date of Birth _____/_____/_____ Subscriber #:_____

**NAME** of Secondary Insurance_____Secondary Subscriber ☐Self ☐Spouse ☐Parent ☐Other

Subscriber Date of Birth _____/_____/_____ Subscriber #:_____

***Responsible Party:** (Name of person financially responsible for this account) ☐Self ☐Spouse ☐Parent ☐Other
Name:_____

Contact #:_____ *DOB:_____*SS#:_____

Billing Address (If different from patient's address) _____

City, State, Zip_____

***Primary Physician**_____City:_____Phone#:_____

***Date you last visited your primary physician (Guarantees payment by your insurance company):** _____/_____/_____

Referring Physician_____ City:_____Phone#:_____

If you were not referred by a physician, how did you hear about us?

☐ Friend/Family_____ ☐ Previous Patient ☐ Internet Search ☐ Social Media ☐ Other

I authorize the release of my medical records & diagnosis to any third-party payers. I authorize payment of medical benefits to Yale Podiatry Group for services. I realize I am responsible for payment for services rendered to me. I authorize the disclosure of my medical history and/or diagnosis by my physician to health personnel when necessary for medical care. I permit a copy of this authorization to be used in place of the original.

Signature_____ Date_____

## Medical History

***Reason for today's visit?**_____Duration:_____

Height: _____ft_____in Weight:_____lbs Shoe Size:_____Shoe Width:_____

**Medications** (If you have a list, you may bring to the front desk to be scanned)

_____

**Allergies:**_____If no known allergies please check ☐

**Past Major Medical Illnesses:** ☐ Head Injury ☐ Seizures ☐ Blood Clots ☐ Heart Attack ☐ Phlebitis ☐ Kidney Disease ☐ Stroke

☐ Rheumatic Fever ☐ Scarlet Fever ☐ Cancer (Explain):_____

Other:_____

**Past Surgical History:**_____

Date of last Tetanus vacc._____Date of last Influenza vacc._____Date of last Pneumonia vacc._____

Social History: Do you smoke? ☐ Yes ☐ No ☐ Previously Do you drink alcohol? ☐ No ☐ Yes, if so ☐ Daily ☐ Occasionally

**Family History: Please check all that apply:** M(Mother) F(Father) S(Sister) B(Brother)

**Foot Problems:** ☐M ☐F ☐S ☐B **Cancer:**☐M ☐F ☐S ☐B **Diabetes:** ☐M ☐F ☐S ☐B

**Hypertension:** ☐M ☐F ☐S ☐B **Heart Disease:** ☐M ☐F ☐S ☐B **TB:**☐M ☐F ☐S ☐B

Other (Explain):_____

**Review of Systems- Current (ACTIVE) conditions**
**Please indicate if you are currently experiencing any of the following conditions**

**HEENT:** ☐Dizziness ☐Frequent Headaches ☐Sinusitis Difficulty: ☐Vision ☐Hearing *Other:*_____

**Cardiovascular:** ☐Angina ☐Blood Clots ☐Heart Attack ☐Hypertension (High Blood Pressure) ☐Palpitations ☐Edema
☐Claudication (Cramping) ☐Varicose Veins ☐Irregular Heartbeat **Pacemaker:** ☐Yes ☐No **Stent:** ☐Yes ☐No
*Other/Explain:*_____

**Orthopedics:** ☐Foot Problem ☐Ankle Problems ☐Knee Problems ☐Hip Problems ☐Back Problems *Other:*_____

**Hematologic:** ☐Taking a Blood Thinning Medication ☐Easy Bruising ☐Phlebitis ☐Anemia ☐Hepatitis *Other:*_____

**Respiratory:** ☐Asthma ☐Bronchitis ☐Chronic Cough ☐Emphysema ☐Shortness of Breath *Other:*_____

**Gastrointestinal:** ☐Colitis ☐Inflammatory Bowel Disease ☐Stomach Ulcer ☐Reflux ☐Hiatus Hernia *Other:*_____

**Genitourinary:** ☐Kidney Disease ☐Hemodialysis ☐Urinary Incontinence ☐Prostate Problem *Other:*_____

**Neuromuscular:** ☐Neuropathy ☐Paralysis ☐Contractures ☐Sciatica ☐Back Pain *Other:*_____

**Rheumatologic:** ☐Arthritis ☐Joint Pain/Swelling ☐Lupus *Other:*_____

**Endocrine:** Diabetes- (☐Type I ☐Type II- If so, last known A1C level:_____) ☐Thyroid Gland Problem ☐Pituitary Gland Problem
*Other/Explain:*_____

**Integumentary:** ☐Skin Allergies ☐Rash ☐Dermatitis ☐Psoriasis ☐Itching Skin *Other:*_____

**OFFICE USE ONLY:** BP:_____P: _____T:_____ R:_____ O:_____ MA's
Initials:_____

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Yale Podiatry Group

## Pharmacy Preferences

Name of my Preferred Pharmacy: _____

Pharmacy Address: _____

Pharmacy Phone #: _____

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**<u>In the event</u> you are prescribed a narcotic please acknowledge the following: This is just an acknowledgement, it does not mean you will be prescribed a narcotic.**

I _____understand that a narcotic **may be** prescribed to me as a part of my treatment plan by my podiatrist. I understand that this medication is to be taken exactly as prescribed and am not to share this medication with anyone. I understand that if my medication or my physical paper prescription for my medication is lost, damaged, or stolen I will not be given another prescription until the date after that one is complete. I understand that there are no exceptions to this policy.
Furthermore, I understand it is my responsibility to inform my podiatrist of any allergies or intolerance I have experienced to any narcotics previously.

_____ Date: _____
Patient Signature

Last Revised: 01/01/2018

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## Medical Records Release

Date: _____

Primary Care Physician: _____

I am hereby requesting that the following medical records be released from my physician to Ansonia Podiatry Associates, LLC for evaluation required for the continuation of my care.

Medical Records:
□ Recent Medication List
□ Recent Lab Work
□ Vaccination Record
□ Last Encounter Chart Notes

Please fax to 203-734-8265

Patient Name: _____DOB: _____

Signed_____