Patient Registration Form

New England Foot & Ankle Specialists

30 New Crossing Road, Suite 311, Reading, MA 01867 (781)-944-4044

Patient Name:____ Date:______________
(First) (M) (Last)

Address:____
(Street) (City) (State) (Zip)

Date of Birth:______________ Sex: M___ F___ Marital Status: S____ M____ W____ D____

Phone: Home_____________________ Cell:___________________ Work:___________________

Best # to reach you at H_____ C_____ W_____ E-Mail:_____________________________________

Primary Care Physician:_________________________________Date of Last Visit:_______________

Location of Primary Care Physician: ____

Emergency Contact/Relation to you:____________________________Phone:___________________

Your Occupation:____

Race: ___White ___Black/African American ___Asian _____Hispanic or Latino _____Other
___American Indian or Alaska Native ____Hawaiian or Pacific Islander

Primary Insurance:____________________________________I.D.#______________________

Policy Holders Name:_________________________DOB:__________Relationship to Patient:_________

Secondary Insurance:__________________________________I.D.#______________________

Is this Worker's Comp: ___Y ___N Auto Accident: ___Y ___N Other Accident: ___Y ___N

How did you learn about our office? Doctor Referral (name)______________________________

Friend_______________________________ Family________________________________

___Hospital (ER) ___Website ___Facebook ___Previous Patient ___Physical Therapy

Chief Complaint (Specific concern you would like addressed by your doctor today?)

____

____

I attest that the information provided on this form is complete and accurate to the best of my knowledge. I hereby authorize Brian Tedesco, DPM & George Abboud, DPM PC dba New England Foot & Ankle Specialists, to furnish any medical information necessary to process insurance claims for my treatment acquired in the course of the examination. I authorize payment of medical and/or surgical benefits to Brian Tedesco, DPM & George Abboud, DPM PC dba New England Foot & Ankle Specialists. I understand that the provider's charge may exceed the insurance allowed amount and payment. I will be responsible for any and all balances such as co-insurance, co-payments and deductibles.

____ ____________________

Signature of Patient/Legal Guardian *Date*

____

Print Name

Past Medical History (Please check all that apply)

___Acid Reflux/GERG
___Alzheimer's/Dementia
___Anemia
___Arthritis
___Asthma
___Bleeding Disorder
___Cancer – Type: ________________
___Chronic Back Pain
___Congestive Heart Failure
___Depression
___Diabetes
___DVT (blood clot in leg)
___Emphysema/COPD
___Fibromyalgia
___Gout
___Heart Attack
___Heart Beat Irregular/Murmur
___Heart Disease
___Heart Pacemaker/AICD
___High Blood Pressure
___High Cholesterol
___Hypothyroid (Low)
___HIV / AIDS
___Kidney Dialysis
___Kidney Disease
___Kidney Stones
___Kidney Transplant
___Liver Disease/Hepatitis/Cirrhosis
___Mental Illness
___Multiple Sclerosis (M.S.)
___Osteoporosis
___Parkinson's
___Peripheral Arterial Disease (PAD of legs)
___Peripheral Neuropathy
___Phlebitis
___Psoriasis
___Pulmonary Embolism (blood clot in lung)
___Raynaud's Disease
___Rheumatoid Arthritis
___Seizures
___Sickle Cell Anemia/Trait
___Sleep Apnea
___Stomach Ulcers
___Stroke
___Other___________________________

Medications

1.______________________________
2..______________________________
3.______________________________
4.______________________________
5.______________________________
6.______________________________
7.______________________________
8.______________________________
9.______________________________

Allergies (Please check all that apply)

___No Known Drug Allergies
___Adhesive Tape
___Aspirin
___Codeine
___Demerol
___Iodine
___IV Dye
___Latex
___Local Anesthetics
___Penicillin
___Sulfa
___Other

Past Surgical History (please check all that apply)

___Amputation
___Angioplasty (Heart Stent)
___Appendectomy (Removal of Appendix)
___Back Surgery
___Bariatric Surgery
___Carpal Tunnel Surgery
___Cholecystectomy (Gall Bladder)
___C-section
___Eye Surgery
___Foot Surgery ___________________
___Heart Bypass
___Hernia Repair
___Hip Replacement
___Hysterectomy
___Knee Replacement
___Knee Scope
___Mastectomy
___Thyroid Removal
___Tonsillectomy
___Vascular Surgery
___Other____________________
___Hospitalizations___________
____

Social History

Do you smoke? ____ Current Smoker - How many packs per day? ______
____ Never Smoked
____ Former Smoker - Quit: _____ Days / Months / Years Ago
Do you drink alcohol? ___Yes ___No How much? __________________
Do you use illicit drugs? (marijuana, cocaine, etc) ___Yes ___No Explain ____________________________

PHARMACY NAME: ____

ADDRESS: ____

Mark the scale to indicate your average pain due to your foot and ankle condition

No Pain	0	1	2	3	4	5	6	7	8	9	10	Severe Pain

Signature of Patient/Legal Guardian: _______________________________________ **Date:** ____________

Physician Signature (Form completely reviewed) _________________________________ **Date:** ____________

FINANCIAL POLICY & CONSENT FOR TREATMENT
for Brian Tedesco, DPM & George Abboud, DPM PC dba New England Foot & Ankle Specialists

Welcome and thank you for choosing Brian Tedesco, DPM & George Abboud, DPM PC dba New England Foot & Ankle Specialists. We are committed to providing you with the highest quality medical care in an efficient, timely and effective manner. Please review our financial policy & consent below. If you have any questions, please feel free to discuss them with our staff.

1. **Insurance Coverage:** Your insurance policy is a contract between you and the insurance company. As a courtesy, we will file your insurance claim for you. This allows the insurance company to pay the doctor's office directly. We are a specialist office and it is always wise to verify your insurance benefits, co-pays, and deductibles prior to your visit or procedure. We will make a copy of your insurance card and driver's license or photo ID during your initial visit. Existing patients are to inform us of any changes in insurance coverage or demographics that may have occurred since your previous visit.

2. **Co-Payments:** Most insurance plans have a Co-payment (co-pay). This is an amount you must pay upon each visit to a doctor. Our policy is to collect your co-payment at the time of service. If you are not prepared to pay the co-payment, the visit will be rescheduled. We accept Cash, Check, and most Credit Cards.

3. **Deductibles:** In Addition to the co-payment, most plans also have an annual deductible. If you have not met your deductible, you will be billed for the anticipated approved insurance amount. Payment is expected at the time of service. In the event there is a balance due from you after your insurance carrier has paid its portion we will bill you. We would appreciate prompt payment of your bill after the first statement. If you do not understand the reason you owe a balance, please do not hesitate to contact our office, and the billing staff will explain the balance to you, and answer any questions you might have. If your account becomes past due, we will refer the overdue balance to an outside collection agency.

4. **Non-Covered Services:** Your insurance plan may not cover all services and/or supplies provided to you during your treatment. In the event your health plan determines a service or item to be "non-covered", you will be responsible for total charges at time of visit or upon receipt of a statement from our office.

5. **Returned Checks:** A $35 fee will be charged for any checks returned by the bank.

6. **Custom Orthotics:** A deposit of half the cost. Will be applied to the full cost of the orthotic. When dispensed the balance will then be collected. If you would like us to bill your insurance company we can do so when orthotics are dispensed to you. If payment is received from the insurance company, we will then reimburse your deposit up to the total paid by your insurance company.

7. **Consent for Treatment:** I hereby authorize the podiatrist and staff of Brian Tedesco, DPM & George Abboud, DPM PC dba New England Foot & Ankle Specialists to prescribe, administer, and perform such physical examinations, radiology examinations, laboratory test, medications, durable medical equipment, procedures and surgery as necessary or advisable in the diagnosis and treatment of my condition. I understand that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been or will be made regarding the results of examinations or treatment in this office.

8. **Authorization to Release Information:** I authorize Brian Tedesco, DPM & George Abboud, DPM PC dba New England Foot & Ankle Specialists. to release and disclose any Private Health Information about me that pertains to any and all medical care, tests, treatment, or advice that was rendered to me by the podiatrists and/or staff of Brian Tedesco, DPM & George Abboud, DPM PC dba New England Foot & Ankle Specialists to any physicians, practitioners, insurance companies, third party payers, authorized agents, claims review organizations, support staff or facility involved in my plan of care or transfer of care and/or Medicare in order to process a claim and/or payment on my behalf.

9. **HIPPA Notice of Privacy Practices:** I acknowledge that a copy of the Brian Tedesco, DPM & George Abboud, DPM PC dba New England Foot & Ankle Specialists HIPPA Notice of Privacy Practices will be made available to me at my request, and that I have read, or had the opportunity to read if I so choose,and understand the Notice.

10. **Payment Agreement:** I understand that by providing a valid and current insurance card prior to services being rendered, Brian Tedesco, DPM & George Abboud, DPM PC dba New England Foot & Ankle Specialists will file a claim to my insurance company but that does not guarantee payment which ultimately, I am responsible for. I hereby accept and assume financial responsibility for any covered or non-covered services rendered to me and will be responsible for any services that are unpaid as a result of not providing Brian Tedesco, DPM & George Abboud, DPM PC dba New England Foot & Ankle Specialists with a valid referral. **If a referral is not obtained and you choose to receive speciality care without the consent of your primary care clinician you acknowledge that you will assume full financial responsibility for the visit.** If there are any questions, problems, or delays regarding my coverage and or benefits. I understand that it is my responsibility to solve these issues with my insurance carrier and the billing office administrator. Deductibles, co-payments, and payment for non-covered services will be due at the time of service.

11. **Cancellation Policy:** We request that you please give our office a 24-hour notice in the event that you need to reschedule your appointment. This will make the appointment time available to someone else. If you miss an appointment and do not contact us with at least 24-hours prior notice, we will consider this to be a no-show appointment and a $50.00 fee will be assessed to you. We do understand that there are times when you must miss an appointment due to emergencies for work or family. However, appointments are in high demand, and cancelling your appointment early enough will give another patient the possibility to have access to timely medical care. If you are more than 10 minutes late for an appointment, we reserve the right to reschedule your appointment. As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive your reminder call or message, the cancellation policy will still remain in effect. It is up to you to keep track of your appointments. ***Your phone call is critical in helping us provide continuous care to all of our valued patients.***

Please sign below if you have read, understand and agree to the above statements.

Signature of Patient or Responsible Person: ____

Printed Name: ____ **Date:** ______________________

MEDICAL RELEASE AUTHORIZATION

I give permission to release my medical information to: (such as a family member, friend, other doctor, etc.)

1. ____
(First & Last Name)

2. ____
(First & Last Name)

3. ____
(First & Last Name)

Patient Signature: ____