Greenville Foot and Ankle Specialists

David M. Colannino, D.P.M **Dominic J. Roda, D.P.M**

Patient Name: _____
(Last) (First) (Initial)

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Sex: M / F**

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Age: ____ **Birthdate:** _____ **SS#:** _____ **Marital Status:** _____

Patient Employed By: _____ **Occupation:** _____

Business Address: _____ **Phone:** _____

Who may we thank for referring you? _____

In Case of emergency who should be notified: _____

Relation: _____ **Phone:** _____

Primary Care Physician: _____ **PCP Phone:** _____

Pharmacy

Name & Address: _____ **State:** _____

Phone: _____

Insurance

Please attach your insurance cards at the top of the clipboard

Assignment and Release

I, the undersigned, certify that I (or my dependent) have current insurance coverage with _____ and assign directly to David M. Colannino, DPM, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient signature -- _____ Date -- _____

David M. Colannno, D.P.M.
Dominic J. Roda, D.P.M.

PERSONAL HEALTH INFORMATION

Do you now or have you ever had:

	YES	NO		YES	NO		YES	NO
DIABETES	___	___	RHEUMATIC FEVER	___	___	ANEMIA	___	___
HEART DISEASE	___	___	RHEUMATOID ARTHRITIS	___	___	PHLEBITIS	___	___
HIGH BLOOD PRESSURE	___	___	GOUT	___	___	HEPATITIS	___	___
STROKE	___	___	EPILEPSY	___	___	ASTHMA	___	___
GLAUCOMA	___	___	THYROID PROBLEMS	___	___	AIDS/HIV	___	___
KIDNEY DISEASE	___	___	LIVER DISEASE	___	___	CANCER	___	___
BLEEDING PROBLEMS	___	___	HEART MURMUR	___	___	GI ULCER	___	___

What medications are you presently taking?

NAME	DOSE	FREQUENCY

Do you have allergies to any medications? _____ ***If yes, to which:***

Social History:

Smoke:	Yes / No	How many packs per day? _____	How many years? _____
Drink:	Yes / No	How many drinks per day? _____	How many years? _____
Drug Abuse:	Yes / No	If yes, what type(s) _____	

Family History:

Do any of your blood relatives have or have ever had:

	YES	NO		YES	NO		YES	NO
DIABETES	___	___	RHEUMATIC FEVER	___	___	ANEMIA	___	___
HEART DISEASE	___	___	RHEUMATOID ARTHRITIS	___	___	PHLEBITIS	___	___
HIGH BLOOD PRESSURE	___	___	GOUT	___	___	HEPATITIS	___	___
STROKE	___	___	EPILEPSY	___	___	ASTHMA	___	___
GLAUCOMA	___	___	THYROID PROBLEMS	___	___	AIDS/HIV	___	___
KIDNEY DISEASE	___	___	LIVER DISEASE	___	___	CANCER	___	___
BLEEDING PROBLEMS	___	___	HEART MURMUR	___	___	GI ULCER	___	___

Surgical History:

Please briefly describe your foot problem(s):

David M. Colannino, D.P.M.
Dominic J. Roda, D.P.M.

Patient Financial Policy

We are dedicated to providing the best possible care and service to you and regard your complete understanding our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures that we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.
- There is a charge of **$40.00** for all missed/broken appointments, or appointments not cancelled with 24 hour notice. This must be paid before any further appointments will be scheduled. Your insurance company does not cover this fee.
- There is a service fee of **$25.00** for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party_____ **Date** _____

Printed Name _____

Witness _____ **Date**_____

Printed Name_____

_____**Patient initials to indicate copy received**

David M. Colannino, D.P.M.
41 Sanderson Road, Suite 207
Smithfield, RI 02917

RECIEPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____ have been provided a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient Date

CREDIT CARD ON FILE POLICY

At Greenville Foot and Ankle Specialists, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. This may include co-pays, co-insurance, and deductibles. Your credit card will **ONLY** be charged if your balance goes more than 90 days past due. If you do not leave a credit card number on file, your past due balance may be subject to collecting additional fees.

Your credit card information is kept confidential and secure and payments to your card are processed **ONLY** after the claim has been filed and processed by your insurance company, and the insurance portion of the claim has been paid and posted to the account.

I authorize Greenville Foot and Ankle Specialist to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ **Amex** ☐ **Visa** ☐ **Mastercard** ☐ **Discover**

Credit Card Number: _____

Expiration Date: ____/____/____

Cardholder Name: _____

Signature: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

I, the undersigned, authorize and request Greenville Foot and Ankle Specialists to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Greenville Foot and Ankle Specialists.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60 day notification to Greenville Foot and Ankle Specialists in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: ____/____/____