Greenville Foot and Ankle Specialists

David M. Colannino, DPM, FACFAS Dominic J. Roda, DPM, FACFAS, CWS
Michael A. Battey, DPM, FACFAS

New Patient Registration Forms

PATIENT INFORMATION			
LAST NAME	FIRST NAME		M.I.
STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	
EMAIL ADDRESS	SEX	D.O.B.	AGE
PREFERRED CONTACT (CIRCLE): EMAIL WORK HOME CELL			
EMPLOYER		OCCUPATION	
PRIMARY CARE PHYSICIAN		PHONE	
REFERRED BY		PHONE	

INSURANCE INFORMATION		
INSURANCE TYPE (CIRCLE): MEDICARE PPO POS EPO HMO WC OTHER _____		
PRIMARY INSURANCE	ID#	RELATIONSHIP TO INSURED SELF SPOUSE DEPENDANT
SECONDARY INSURANCE	ID#	RELATIONSHIP TO INSURED SELF SPOUSE DEPENDANT

INSURED INFORMATION (IF OTHER THAN PATIENT)		
INSURED LAST NAME	FIRST NAME	M.I.
PHONE #		D.O.B.

AUTHORIZATIONS, ASSIGNMENTS, SIGNATURE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Greenville Foot and Ankle Specialists to use and disclose my individually identifiable Protected Health Information (PHI) in the manner described below. I understand that my PHI may be re-disclosed by the person or entity receiving it and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such re-disclosure by the person or entity receiving my PHI. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

☐ I hereby authorize the use of my PHI for the purpose of diagnosing, treating, consulting, and referral.
☐ I hereby authorize the disclosure of my PHI to insurance carriers and/or its representative for processing claims.

ASSIGNMENT OF BENEFITS

I hereby authorize payments to be made directly to Greenville Foot and Ankle Specialists for surgical and/or medical benefits, if any, otherwise payable to me for professional services rendered. I understand that I am financially responsible for the charges not covered by this Authorization. I further agree, in the event of non-payment, to bear the cost of reasonable legal fees should this be required. A photocopy of this assignment shall be considered as effective and valid as the original.

SIGNATURE_____ **IF MINOR, PARENT/GUARDIAN MUST SIGN** **PLEASE PRINT NAME** _____	**DATE**

Smithfield Medical Center | 41 Sanderson Road | Suite 104 | Smithfield, Rhode Island 02917-2603
T 401.949.3220 | F 401.949.3296

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CHIEF COMPLAINT HISTORY
PLEASE DESCRIBE THE REASON FOR YOUR VISIT:
DATE OF INJURY OR ONSET AND DURATION:
DESCRIBE YOUR SYMPTOMS: __PAIN __SWELLING __BURNING __TINGLING __NUMBNESS __PAIN AT REST __PAIN WITH ACTIVITY __OTHER SYMPTOMS:
WHAT TREATMENTS HAVE YOU TRIED? __ORTHOTICS __MEDICATIONS __INJECTIONS __SURGERY __PHYSICAL THERAPY __OTHER:

HEALTH HISTORY				
☐ARTHRITIS TYPE:	☐DIABETES TYPE:	☐NEUROPATHY	☐BACK PAIN	☐GOUT
☐STROKE	☐ CANCER TYPE:	☐ CHEMICAL DEPENDENCY	☐ASTHMA	☐RESPIRATORY PROBLEMS
☐KIDNEY DISFUNCTION	☐LIVER DISEASE	☐ HEPATITIS	☐LOW BLOOD PRESSURE	☐HIGH BLOOD PRESSURE
☐CIRCULATION PROBLEMS	☐ HEART PROBLEMS	☐ARTIFICIAL HEART VALVE	☐CHF	☐EPILEPSY
☐OBESITY	☐ UNEXPLAINED WEIGHT LOSS	☐ AIDS/HIV	☐FAINTING	☐ FIBROMYALGIA

MEDICATIONS WITH DOSAGE (PLEASE INCLUDE OTC MEDS)

PHARMACY (NAME AND LOCATION)	PHONE

ALLERGIES			
☐NO KNOWN ALLERGIES	☐LATEX	☐LOCAL ANESTHETIC NOVOCAINE LIDOCAINE	☐CODEINE
☐PENICILLIN	☐SULFA	☐IODINE SKIN / IV	☐ANTI-INFLAMATORIES
☐SEAFOOD	☐ADHESIVE/TAPE	☐GENERAL ANESTHESIA	☐ASPERIN
☐IV CONTRAST DYE	☐OTHER:		

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SURGICAL HISTORY			
SURGICAL PROCEDURE	YEAR	SURGEON OR HOSPITAL	COMPLICATIONS?

SOCIAL HISTORY			
TYPES OF EXERCISE:			
ARE YOU PREGNANT? YES NO	SHOE SIZE:	HEIGHT:	WEIGHT:
DO YOU DRINK ALCOHOL? ☐ NEVER ☐ QUIT ☐ OCCASIONALLY ☐ REGULARLY ☐ HEAVILY			
DO YOU SMOKE? ☐ YES ☐ NO IF YES, PACKS PER DAY:		FORMER SMOKER? ☐ YES ☐ NO	

REVIEW OF SYSTEMS				
PLEASE CHECK ANY SYMPTOMS YOU HAVE HAD IN THE PAST 3 MONTHS				
GENERAL	☐ FEVER	☐ CHILLS	☐ FATIGUE	☐ WEIGHT GAIN/LOSS
HEAD	☐ HEADACHES	☐ VISUAL PROBLEMS	☐ HEARING PROBLEMS	☐ NECK PAIN
CARDIOVASCULAR	☐ CHEST PAIN	☐ PALPITATIONS	☐ DIZZINESS UPON STANDING	☐ LEG PAIN WHEN WALKING
HEMATOLOGY	☐ ABNORMAL BLEEDING	☐ BRUISING	☐ BLOOD CLOTS	☐ DELAYED HEALING
RESPIRATORY	☐ PERSISTENT COUGH	☐ WHEEZING	☐ SHORTNESS OF BREATH	☐ PAIN ON BREETHING
GASTROINTESTINAL	☐ DIFFICULTY SWALLOWING	☐ INDIGESTION OR HEARTBURN	☐ ABDOMINAL PAIN	☐ CHANGE IN BOWEL HABITS
URINARY	☐ PAIN ON URINATION	☐ FREQUENT URINATION	☐ INCONTINENCE	☐ BLEEDING ON URINATION
MUSCULOSKELETAL	☐ JOINT PAIN OR SWELLING	☐ JOINT STIFFNESS	☐ CRAMPING	☐ WEAKNESS
SKIN	☐ SKIN RASH	☐ ABNORMAL SKIN LESIONS	☐ ITCHING	☐ WOUNDS OR ULCERS
NEUROLOGICAL	☐ NUMBNESS	☐ SEIZURES	☐ TREMORS	☐ PARALYSIS
PSYCHIATRIC	☐ DEPRESSION	☐ ANXIETY	☐ INSOMNIA	☐ MEMORY LOSS
ENDOCRINE	☐ HEAT/COLD INTOLERANCE	☐ HOT FLASHES	☐ CHANGE IN HAIR/SKIN	☐ EXCESSIVE SWEATING

CONSENT FOR TREATMENT

The information provided here is true to the best of my knowledge. I hereby authorize release of any previous medical records by fax, mail, or phone to either a treating physician or hospital. I also give permission to the physician or assistants to initiate the diagnosis and treatment of my condition with examination, imaging studies, and/or photographs as deemed medically relevant and necessary.

SIGNATURE _____ DATE_____

If minor, parent/guardian must sign.

Please print name_____

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Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information discussed with family members you must sign this form.

By signing this form, you only give your consent to discuss your medical and billing information with the family members indicated below.

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Patient Name: _____ Date: _____

Patient Signature: _____

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Financial Policy

Your clear understanding of our Financial Policy is important to our professional relationship.

• We need a current copy of your insurance card to bill your insurance directly for the charges and services rendered.
• If you do not provide us with a current insurance card or do not have insurance, full payment is due at the time of service. We accept cash, check, or credit card (Visa, MasterCard, or Discover).
• Please notify us immediately if there are any changes to your insurance plan or your coverage.
• Co-payments and deductibles are an agreement between you and your insurance plan, are your responsibility, and are not something we can negotiate.
• Co-payments are due at the time of service and charges to cover your deductible may be requested to be paid.
• Medical records or copies of records can be provided at your request; please allow up to 5 business days for records to be compiled. There may be a nominal fee for record copying.

SELF PAY
We expect full payment at the time of service unless prior arrangements have been made.
MEDICARE
We accept Medicare assignments. There are some services and supplies that are not covered by Medicare. We will advise you if there are any non-covered charges prior to that service being provided.
HMO/PPO
We are providers for many insurance plans but are not all plans. You are responsible for verifying that we are providers for your plan. If you are an HMO member, you must have a current referral at the time of your visit in order to be seen, and for the visit to be covered under your plan. Without a proper referral, you may be responsible for charges incurred.
If you are a PPO member, you are responsible for co-payments, deductible, and co-insurance. Please confirm with your insurance that we are providers covered under your plan.
WORKERS' COMPENSATION
If you are consulting with us regarding a work-related injury, we require information for both your personal insurance coverage as well as your employer's Workers' Compensation insurance. Prior to being evaluated in our office, we need to have a letter or statement from Workers' Compensation carrier authorizing your treatment. The letter should include the claim number, address, adjuster's name, and phone number. Your employer's human resources office should be able to assist you with obtaining this information. If payment is not received from these third parties within 90 days, we reserve the right to bill you directly.
HOSPITAL AND SURGERY CENTER CHARGES
In the event that you undergo surgery in a hospital or outpatient surgery center, separate charges will be made by the facility. Your podiatric physician with University Foot & Ankle Institute may be part ‹owner or have financial interest in a surgery center where you will be having surgery.

FINANCIAL AGREEMENT	
I understand that I am financially responsible for all charges not covered by my insurance. I guarantee my balance will be paid by cash, check, or credit card. Past-due balances may be subject to additional fees. I also understand that if the office agrees to bill insurance, I must submit information as needed in a timely manner, to ensure payment for services rendered. I understand that I am ultimately responsible for payment of all services.	
Patient or Parent/Guardian Name (please print):	
Signature:	Date:

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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 does not 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.

ACCEPT

I, (print name) _____ have read and understand the above-mentioned policy and agree to leave my credit card on file. I authorize Greenville foot and Ankle Specialists to charge my credit card for payments owed to my account for services rendered at their office, in the event my account becomes overdue past 30 days. I agree to update any information regarding this account. This information is complete to the best of my knowledge.

Patient's Signature _____
Date_____

Parent/Guardian Signature (if minor) _____
Date_____

CREDIT CARD INFORMATION

Name on Card:		Card #:
Card Type:	Exp. Date:	CVV:

DECLINE

I, (print name) _____ decline to leave my credit card on file. I understand that I will need to pay upfront an estimate of the co-insurances or deposit for services provided today. Once claims have been processed and settled with my insurance company, I will be refunded if my account has any credit due or will be charged any additional balance the insurance company makes me responsible for.

Patient's Signature _____
Date_____

Parent/Guardian Signature (if minor) _____
Date_____

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To Our Patients: THIS OFFICE REQUIRES YOU TO LEAVE A CREDIT CARD ON FILE.

Similar to hotels and car rental agencies, you are asked for a credit card number at the time you check in and the information will be held securely until your insurance company has paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. What we are doing is nothing different than a hotel or rental Car Company does at each check-in. All credit card contracts give cardholders the right to challenge any charge against their account.

Credit Card Policy FAQs

What is a Deductible and How Does It Affect Me? An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance coverage begins to pay. For example, if the policy has a $500 deductible, you must pay the first $500 of medical expenses before the Insurance company begins to pay for any services.

When do I have to pay for services? Any time you receive medical care, you are expected to pay in full for your services until your deductible is met.

How will I know when my deductible has been met? Call your insurance company at any time to check on how much of your deductible has been met; some insurance companies have this information available online. Every time you receive medical services, you will receive notification from your insurance company with how much they paid or did not pay. As a service to our patients, we try our best to verify the benefits for you as well.

How will I know how much is being charged on my credit card? For every visit or surgery, your insurance company mails an Explanation of Benefits (EOB) to you. This document shows how much your insurance paid and what you need to pay based on the benefits of your policy. This office receives the same information that you do from your Insurance Company. We apply the payment (if any) and make any discount or adjustment as per our contract with your insurance company. The balance on your account for that visit or surgery will then match the patient responsibility amount on your EOB. This is the amount that will be charged to your credit or debit card. A receipt will be sent to you via email.

What If I have 2 insurance plans? You are very fortunate!! Each plan may have different policy benefits and deductibles. Again, we will ask that you put a credit or debit card on file just in case these plans do not cover all your services. Remember, we will not access this information until both plans have paid AND if there is a remaining patient responsible balance.

I don't really know my insurance benefits. Can you tell me what they are? Unfortunately, there are SO many health plans that we are not able to know them all. We do try our best to verify that insurance plans are effective and what the status of your deductible, coinsurance and co pay may be, but we do not always know the exact benefits of your plan.

I've never had to do this before at any other doctor's office. This may be a departure from what you have been used to but it is not uncommon in many medical practices, imaging centers, outpatients surgical centers require a credit card on file.

Why am I being singled out? I always pay all my bills. All patients are required to keep a credit or debit card on file. This policy **isn't** personal; we apply it equally to all of our patients; by doing it this way, the temptation to play favoritism is eliminated and it removes us from the uncomfortable situation of having to decide who has to follow the policy and who does not.

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What about identity and privacy? Under HIPAA, we are under strict rules and guidelines in terms of protecting patient privacy and the credit card is considered protected health information. Because of HIPAA rules, our medical office is far more secure than most retail establishments as it relates to identity theft.

What if I don't have a credit card? You may leave a debit card, HAS (Hea1th Savings Account), or Flex Plan card on file, or pay with cash or check for the visit in full.

This is NOT the same as "balance billing." "Balance billing" is asking the patient to pay the difference between our normal fee and the insurance company's normal payment. That's a breach of our insurance contracts. What we charge to the patient's credit card is the portion the insurance company determined is not covered by the company. For example, if your insurance approves $100, and pays 80% of that amount the other $20 is the patient's responsibility and is what we charge to the credit card - instead of sending out a statement for that amount.

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