

Northtown Podiatry

You have an appointment on _____ @ _____

You will be seeing the following physician

Dr. Joseph M. Anain, Jr.

Dr. Michael Butler

Dr. Daniel Keating

Dr. Sean Keating

Dr. Jules Bodo

Your appointment is scheduled at the following Location

9600 Main Street – Suite 2 Clarence, NY 14031. Office (716)759-2004 Fax (716)759-2009

2121 Main Street – Suite 214 Buffalo, NY 14214. Office (716)838-2983 Fax (716)838-2942. Parking for this office is a paid parking lot in front of Sisters Hospital. The maximum amount you will be charged is \$5.00.

WE DO NOT VALIDATE PARKING

30 North Union Road Williamsville, NY 14221. Located in the office building for Primary Care of WNY. Dr. Anain is the only physician located at that office on Wednesday mornings only. Please call one of the numbers above for any information.

Please complete the enclosed paperwork and bring with you on the day of your appointment.

Please bring insurance cards with you. If you are not the subscriber please know the subscribers date of birth.

Please bring a current list of all your medications.

Per Medicare's guidelines all patients that have Medicare insurance have to be seen every 6 months by their Primary Care Physician. In order for Medicare to cover their office visit here at Northtown Podiatry the date has to be listed on the forms provided to you by our office. Please remember the date you were last seen by your Primary Care Physician has to be within the last 6 months. If the date last seen is incorrect the patient will be responsible for all charges pertaining to their visit at Northtown Podiatry. If you have not been seen by your Primary Care physician or do not know the date you were last seen your appointment will be rescheduled. If you have any questions please do not hesitate to speak with our staff.

If your insurance requires a referral, you must have one in place or you will not be seen.

All copays are due at the time of your visit when you check in with the receptionist. We accept cash, credit cards or checks. If you do not have your copay at the time of service you will not be seen.

If you have any questions please do not hesitate to call either one of our offices.

Northtown Podiatry Appointment Policy

Appointment Time

When we schedule appointments, the needs of our patients are always taken into consideration. If you are going to be more than 5 minutes late for your appointment, we request that you call our office. If you arrive more than 15 minutes late your appointment will be cancelled and rescheduled. We work diligently to stay on schedule and ask that you arrive 15 minutes prior to your appointment time to allow time for necessary paperwork and updating information.

Appointment

Our office requires a minimum of 24 hours' notice when cancelling your appointment. If you fail to notify our office 24 hours prior to your scheduled appointment you will be charged a \$50.00 fee.

If you are a new patient and do not show up or do not call to cancel as stated above you will be charged a \$100.00 missed appointment fee.

*****Payment must be made before scheduling another appointment*****

If you are an established patient and do not show up or call to cancel as stated above you will be charged a \$75.00 missed appointment fee.

***** Payment must be made before scheduling another appointment*****

Age of Patients

Northtown Podiatry will not see any patient under the age of 18 without a parent/guardian present.

Balances

If there is a balance owed on your account we will require payment bringing your account up to date before scheduling an appointment.

Patient Signature: _____

Print Name: _____

Date: _____

NORTHTOWN PODIATRY - MEDICAL HISTORY

PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

ASTHMA	<input type="checkbox"/> YES <input type="checkbox"/> NO	HIGH BLOOD PRESSURE	<input type="checkbox"/> YES <input type="checkbox"/> NO	OSTEOARTHRITIS	<input type="checkbox"/> YES <input type="checkbox"/> NO
BLEEDING DISORDER	<input type="checkbox"/> YES <input type="checkbox"/> NO	HYPOTHYROID	<input type="checkbox"/> YES <input type="checkbox"/> NO	OSTEOPOROSIS	<input type="checkbox"/> YES <input type="checkbox"/> NO
DIABETES	<input type="checkbox"/> YES <input type="checkbox"/> NO	IMMUNE DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	POOR CIRCULATION	<input type="checkbox"/> YES <input type="checkbox"/> NO
DIALYSIS	<input type="checkbox"/> YES <input type="checkbox"/> NO	JOINT REPLACEMENT	<input type="checkbox"/> YES <input type="checkbox"/> NO	POOR HEALING	<input type="checkbox"/> YES <input type="checkbox"/> NO
EXCESSIVE SCARRING	<input type="checkbox"/> YES <input type="checkbox"/> NO	KIDNEY DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	RECREATIONAL DRUG USE	<input type="checkbox"/> YES <input type="checkbox"/> NO
GASTROINTESTINAL DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	LIVER DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	RHEUMATOID ARTHRITIS	<input type="checkbox"/> YES <input type="checkbox"/> NO
GLAUCOMA	<input type="checkbox"/> YES <input type="checkbox"/> NO	LUNG DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	STDs	<input type="checkbox"/> YES <input type="checkbox"/> NO
HEART DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	METAL ALLERGY	<input type="checkbox"/> YES <input type="checkbox"/> NO	SKIN DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO
HEPATITIS	<input type="checkbox"/> YES <input type="checkbox"/> NO	NEUROLOGICAL DISORDER	<input type="checkbox"/> YES <input type="checkbox"/> NO	STOMACH ULCER	<input type="checkbox"/> YES <input type="checkbox"/> NO
OTHER _____					

HEIGHT: _____ WEIGHT: _____

REVIEW OF SYSTEMS

ENDOCRINE:	EXCESSIVE THIRST	<input type="checkbox"/> YES <input type="checkbox"/> NO	SORE/RED EYES	<input type="checkbox"/> YES <input type="checkbox"/> NO	BRITTLE/LOSS OF HAIR	<input type="checkbox"/> YES <input type="checkbox"/> NO
VASCULAR:	LEG PAIN WHILE WALKING	<input type="checkbox"/> YES <input type="checkbox"/> NO	SWELLING	<input type="checkbox"/> YES <input type="checkbox"/> NO	COLD TOES	<input type="checkbox"/> YES <input type="checkbox"/> NO
GI:	REFLUX/INDIGESTION	<input type="checkbox"/> YES <input type="checkbox"/> NO	STOMACH PAIN	<input type="checkbox"/> YES <input type="checkbox"/> NO	DIARRHEA	<input type="checkbox"/> YES <input type="checkbox"/> NO
GU:	EXCESSIVE URINATION	<input type="checkbox"/> YES <input type="checkbox"/> NO	BURNING URINATION	<input type="checkbox"/> YES <input type="checkbox"/> NO	PAINFUL URINATION	<input type="checkbox"/> YES <input type="checkbox"/> NO
SKIN:	RASH	<input type="checkbox"/> YES <input type="checkbox"/> NO	ITCHING	<input type="checkbox"/> YES <input type="checkbox"/> NO	CHANGING MARKS ON SKIN	<input type="checkbox"/> YES <input type="checkbox"/> NO
	PEELING SKIN	<input type="checkbox"/> YES <input type="checkbox"/> NO	BLISTERS	<input type="checkbox"/> YES <input type="checkbox"/> NO	BRUISES	<input type="checkbox"/> YES <input type="checkbox"/> NO
NEUROLOGIC:	TREMORS	<input type="checkbox"/> YES <input type="checkbox"/> NO	NUMB FEET/LEGS	<input type="checkbox"/> YES <input type="checkbox"/> NO	BURNING FEET/LEGS	<input type="checkbox"/> YES <input type="checkbox"/> NO

SURGERIES YOU HAVE HAD _____

HOSPITALIZATIONS OTHER THAN FOR THE SURGERIES LISTED _____

WHAT IS THE CHIEF COMPLAINT FOR YOUR VISIT TODAY _____

IS THERE A FAMILY HISTORY OF DIABETES YES NO. If yes please list family _____

HISTORY OF SMOKING YES NO FORMER.

ACTIVITIES IN WHICH YOU PARTICIPATE IN (INCLUDE FREQUENCY) _____

MEDICATIONS: _____

ALLERGIES: ADHESIVE TAPE ANESTHESIA CODEINE DEMEROL IODINE
 METAL PENICILLIN SULFA NSAIDS (LIKE MOTRIN)
 OTHER _____

PHARMACY NAME AND ADDRESS: _____

TREATMENT CONSENT

I HEREBY CONSENT AND GIVE MY PERMISSION TO THE DOCTOR (AND THE DOCTOR'S ASSISTANTS OR DESIGNATED REPLACEMENT) TO ADMINISTER AND PERFORM SUCH PROCEDURES UPON ME AS THE DOCTOR DEEMS NECESSARY.

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

DATE

PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

RELATIONSHIP TO PATIENT

NORTHTOWN PODIATRY – FINANCIAL RESPONSIBILITY

INSURANCE COVERAGE

At Northtown Podiatry, we strive to give you the best possible care. In order to serve this purpose, it is important that you understand the mechanisms of reimbursement. Please read this Financial Responsibility Form and sign at the bottom to acknowledge that you understand your accountability.

We attempt to verify that your coverage is valid at the time of the visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for payment is yours.

If you have had any changes in your insurance coverage – even if there is only a small change in the co-payment amount or a change in the expiration date of the policy – you must notify us. Even a small discrepancy on the claim form can lead to a claim denial.

CO-PAYMENTS

Co-payments are your responsibility. Your insurance company expects us to collect them from you at the time of service. Understand that you will be expected to pay your co-payment for each and every date of service on the day of service or you will be rescheduled. **An additional \$25.00 surcharge fee will be added to your account for any billed copay.**

Private Pay (no insurance) Office Visits Only - Patients who seek treatment without insurance will be required to pre-pay an estimated \$125.00 for an Initial Office Visit (new patient), an estimated \$75.00 for a Follow up visit (established patient) and an estimated \$50.00 for Routine Foot Care (established patient).

CO-INSURANCES AND DEDUCTIBLES

Many private insurance companies have a coinsurance for us to collect. In case of a co-insurance we will collect on the date of service.

You are also responsible for your deductibles. The deductible is determined by your individual contract with your insurance carrier. We do not have information about each person's deductible amount, and how much of that has been met. You will be responsible for finding out all information about your deductible prior to your appointment to the office. **We will collect a Prepayment in the amount of \$125.00 for office visit services.** Pre-collection amounts are estimates only as we are unable to determine services prior to being seen. You will be billed for any remaining amount due or refunded should you overpay after your bill is processed by your insurance company.

REFERRALS AND/OR AUTHORIZATIONS

Many insurance carriers require pre-authorization and/or a referral for each visit with us. You are responsible for obtaining these referrals or authorizations (per your contract with your health insurer). You may need to work with your primary care provider in order to obtain this. Contact your insurance carrier if you have any questions regarding what type of services require pre-certification. If you do not have an updated or new referral, your appointment will be cancelled until one is obtained.

INSURANCE PAYMENTS SENT TO YOU

If insurance payments are sent to you erroneously, you are responsible for forwarding them to our office.

Lab Fees

Different insurance companies use different lab companies exclusively, and sometimes will not pay if you are sent to the wrong lab.

Please note that you are responsible for familiarizing yourself with your insurance carrier requirements and notifying the physician and/or office staff on what lab your insurance company uses.

Quest is the most commonly used lab in our area, and we will most likely be sending you there.

Northtown Podiatry is not responsible for charges incurred if your insurance company does not participate with that lab.

Forms Fee

A fee of \$25.00 is charged **PRIOR** to completion of disability forms. This fee is not covered by your insurance. You are responsible for payment. Failure to pay prior to completion will result in the form(s) not being completed.

Medical Records Fee

Copies of Medical records are available upon request. A fee of \$0.75 per page will be charged for medical records.

NON-COVERED SERVICES

All patients are responsible if their insurance carrier denies payment for services rendered because they were “non-covered services.” These non-covered services may include certain treatment types, lab testing, supplies or devices, etc. To avoid this, please check with your insurance carrier prior to receiving any treatment.

I have read and fully understand this Financial Responsibility Form. I acknowledge my personal financial responsibility and I consent to continue with treatment.

/ /

Signature

date

Print Name

