Welcome to 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

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.

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 – PATIENT INFORMATION

_____ /_____/_____M/F
Last Name First Middle Initial Today's Date

_____
Home Address City State Zip Code

(_____)_____(_____)_____(_____)_____/___/_____-_____-_____
Home Phone Cell Phone Work Phone DOB Social Security Number

_____
Employer/Occupation Address City State Zip Code

_____(_____)_____
Emergency Contact Person Relationship Telephone Number

Email Address: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow/Widower

Race: ☐White ☐African American ☐Hispanic ☐Asian ☐Other_____

_____(_____)_____/_____/_____
Primary Care Physician Telephone number Date last seen

Primary Insurance Information:

_____/____/_____-_____-_____
Subscriber's Name Subscriber's DOB Subscriber's Social Security Number

_____
Subscriber's Employer

_____/_____/_____
Name of Insurance Identification Number Group Number Effective Date

Secondary Insurance Information:

_____/____/_____-_____-_____
Subscriber's Name Subscriber's DOB Subscriber's Social Security Number

_____
Subscriber's Employer

_____/_____/_____
Name of Insurance Identification Number Group Number Effective Date

NORTHTOWN PODIATRY - MEDICAL HISTORY

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

ASTHMA	__ YES __ NO	HIGH BLOOD PRESSURE	__YES __ NO	OSTEOARTHRITIS	__ YES __NO
BLEEDING DISORDER	__ YES __ NO	HYPOTHYROID	__ YES __ NO	OSTEOPOROSIS	__ YES __ NO
DIABETES	__ YES __ NO	IMMUNE DISEASE	__ YES __ NO	POOR CIRCULATION	__ YES __NO
DIALYSIS	__ YES __ NO	JOINT REPLACEMENT	__ YES __ NO	POOR HEALING	__ YES __ NO
EXCESSIVE SCARRING	__ YES __ NO	KIDNEY DISEASE	__ YES __ NO	RECREATIONAL DRUG USE	__ YES __ NO
GASTROINTESTINAL DISEASE	__ YES __ NO	LIVER DISEASE	__ YES __ NO	RHEUMATOID ARTHRITIS	__ YES __ NO
GLAUCOMA	__ YES __ NO	LUNG DISEASE	__ YES __ NO	STDs	__ YES __ NO
HEART DISEASE	__ YES __ NO	METAL ALLERGY	__ YES __ NO	SKIN DISEASE	__ YES __ NO
HEPATITIS	__ YES __ NO	NEUROLOGICAL DISORDER	__ YES __ NO	STOMACH ULCER	__ YES __ NO

OTHER _____

_____ **HEIGHT: _____ WEIGHT: _____**

REVIEW OF SYSTEMS

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

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).

The above charges are only for the Office Visit. If you are paying cash for your visit we have attached a list of some of the procedures that are done in our office along with the fees associated with them.

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 $100.00 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.

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

NORTHTOWN PODIATRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by law to provide you, or allow your review of, the Notice of Privacy Practices of Northtown Podiatry, which states how we use and/or disclose your Protected Health Information (PHI).

In review, some of the ways we may use and/or disclose your PHI are for the following purposes:

- **Treatment-** We may disclose information necessary for your medical treatment and care. We may disclose information to those involved in your healthcare (e.g. physicians, family members, pharmacies, labs, etc.)
- **Payment-** we may disclose information needed to file claims and bill for medical services.
- **Health Care Operations-** we may disclose PHI to carry out certain health care operation (e.g. surveys, newsletters, quality assurance, etc.)
- **Public Health**

In order for us to be able to share this information with others, we need you to list people we may contact.

I, _____, give permission to Northtown Podiatry to disclose PHI to:

_____
_____
_____

Additional disclosures require your signed authorization to be kept on file in our office.

On occasion, we may need to contact you at home or an alternate site to assist us in carrying out your care. Please indicate how you would like to be contacted by Northtown Podiatry staff.

- For written communications: Address: _____
  _____
  _____
- For oral communications: Call: _____
  (telephone number)
  May we leave a message?
  YES ____ NO____

I hereby acknowledge receipt of the Notice of Privacy Practices of Northtown Podiatry or have had the opportunity to review the Notice and accept it as written.

_____ _____
(Signature of Patient or Legal Guardian) (Date)

_____
(Print name of Patient or Legal Guardian)

_____

Patient refused to sign acknowledgement of Notice of Privacy Practices.

_____

Date: **Initials** **Reason**