FABRY FOOT AND ANKLE

Welcome to our practice!

In order for us to serve you today and effectively bill your insurance carrier, please fill out this form completely and provide us with a valid insurance and photo ID cards. Thank you in advance!

Patients legal name:_____
FIRST MIDDLE LAST

Preferred name, if different:_____ Sex: M F

Date of Birth: _____ Social Security number:_____
MM/DD/YYYY

PATIENT CONTACT INFORMATION: CHECK IF YOU DON'T HAVE

Email:_____ ☐

Can we send you email notifications about upcoming appointments? Yes No

Mobile phone:_____ ☐

Home phone:_____ ☐

Address:_____
STREET ADDRESS CITY STATE ZIP

IMPORTANT!! *If the patient is a child or dependent, or the insurance holder is your spouse, the person who carries the insurance for the patient referred to as your guarantor. We require certain information below for guarantors. If you are not sure, please provide this info anyway. If we do not have it, it can delay processing or reject your insurance claim:

Patient's relationship to guarantor: (circle one) self spouse child other

Guarantor info:_____
FIRST NAME LAST NAME STREET ADDRESS CITY STATE ZIP

_____ MALE FEMALE _____
DOB:MM/DD/YYYY SEX (CIRCLE) SOCIAL SECURITY NUMBER PHONE NUMBER

My preferred language is: ☐English ☐Other:_____

What is the patient's race: (circle) American Indian or Alaska Native Asian Black or African American

Native Hawaiian or Pacific Islander White Decline to specify

Who is your primary care/family doctor? _____ Date last seen _____

_____
STREET ADDRESS CITY STATE ZIP PHONE NUMBER FAX NUMBER

Who is your emergency contact/next of kin?_____
FIRST NAME LAST NAME PHONE NUMER

What is your relation to this person?_____

Cherrie Fabry Cindric, DPM, FACFAS
700 Pellis Road • Greensburg, PA 15601
724.832.1000

Past Medical History: *circle those pertaining to you*

NONE	Anemia	Anxiety
Arthritis	Asthma	Cancer
Dementia	Depression	Diabetes 1
Diabetes 2	Last A1C	
Drug Abuse	Fibromyalgia	GERD
Gout	Heart Disease	Hepatitis
↑cholesterol	↑blood pressure	HIV
IBS	Kidney disease	Liver disease
MRSA	Osteoporosis	Spinal injury
Spinal stenosis	Stroke	Thyroid disease

OTHER:_____

Medications: please list or provide a printed/written list for us to record in your chart. ☐ **check here if you take no medications**

Medication Dosage

_____

_____

_____

_____

_____

We have the ability to communicate with your pharmacy to obtain and update your prescription information electronically. Do we have your permission to do so? ☐ YES ☐ NO

What is your preferred pharmacy? Name and phone number.

_____

Allergies: *If you have allergies, please grade the allergy as mild, moderate, or severe, and list your reaction:*

Allergen Mild/mod/severe Reaction

_____

_____

_____

_____

Social History: *Do you. . .*

-Smoke? N Y, for _____years, ____packs/day
Date quit:_____

-Use alcohol? N Y If yes, is it…..

Occasional 1-4 drinks/wk Moderate 5-13 drinks/wk Heavy >14 drinks/wk

-Use illegal drugs? N Y

If yes, what type?_____

Surgical History: Please list any prior surgeries, including those to your foot or ankle:

_____

_____

_____

_____

What is your chief complaint for your podiatrist today? SPECIFY

_____

_____

_____

_____

_____

What is your shoe size?_____

Is this an injury that occurred at work? Yes No

Will this be a work comp claim? Yes No

If so, date of injury: _____

Did you miss work due to this injury/condition? Yes No

HIPAA Release: I certify that, in addition to providing the above information, I have been allowed to review the HIPPA privacy acts, and understand that my Private Health Information will not be sold or shared without my permission.

Signature:_____ Date:_____

Consent to treatment, coordination of care, and billing of insurance: I agree, by signing below, that the information given is correct to the best of my knowledge and I consent to such diagnostic procedures (including x rays) and medical care/treatment as deemed necessary by Dr. Cindric. I also authorize Dr. Cindric to discuss my medical issues with other physicians of mine in the best interest in my overall patient care, if necessary. I also authorize release of information to SMB Medical Billing as necessary to file a claim with my insurance company, and assign all benefits payable to Dr. Cindric. I understand I am financially responsible for any balance not covered by my insurance carrier, including any deductible and copayments, as delineated in the practices' financial policy that has been provided to me.

Signature:_____ Date:_____

Thank you for taking the time to fill out this form completely. While much of the information may seem unnecessary or redundant, it will help us to serve you better today and in the future. If you have any questions or need assistance in filling it out, please ask at the front desk. Please return this to the front desk staff when complete, with your insurance card and photo ID. *Thank you!*

Patient Financial Policy

Your understanding of our financial policies is 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 certain 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.
- 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 or referrals; 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 for which 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 costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- 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: _____

Printed Name of Patient/Responsible Party _____ Date: _____

_____ Patient initials to indicate copy received.

Revised June 2015