Monroe Podiatry Group

Today's Date: _____ **Chart number** _____

Name: _____ **DOB:** __/___/___ **Sex:** ☐ M ☐ F **SS#** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Cell phone: _____ **Home Phone:** _____ **Other:** _____

Which phone is primary? ☐ Cell ☐ Home ☐ Other **Marital Status:** ☐ single ☐ maried ☐ widowed ☐ divorced

Email address: _____

Pharmacy name: _____ **Pharmacy phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Care Physician: _____ **Phone:** _____ **Date Last Seen:** ___/___/____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Insurance: _____ **Are you the subscriber?** ☐ Yes ☐ No

Policy ID: _____

Subscriber Name: _____ **Relation:** ☐self ☐spouse ☐child ☐ other

Address: _____ **DOB:** ___/___/____ **Sex:** ☐ M ☐ F

Secondary Insurance: _____ **Are you the subscriber?** ☐ Yes ☐ No

Policy ID: _____

Subscriber Name: _____ **Relation:** ☐self ☐spouse ☐child ☐ other

Address: _____ **DOB:** ___/___/____ **Sex:** ☐ M ☐ F

How did you hear about our practice? ☐ Physician ☐ Family member ☐ Friend ☐ Internet
☐ Other _____

What is the reason for your visit today? _____

_____ **Result of accident or work injury?** ☐ Yes ☐ No

The pain quality is: ☐ burning ☐ constant ☐ dull ☐ sharp ☐ shooting ☐ thobbing ☐ tingling ☐ other _____

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ yesrs

Please read and sign:

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signiture: _____ **Date:** _____

Monroe Podiatry Group

Today's Date: _____ Chart number _____

Height: _____ Weight: _____

Current Medications

☐ No Known Medications ☐ I take the following Medications:

Name/Dose: _____ Name/Dose: _____
Name/Dose: _____ Name/Dose: _____
Name/Dose: _____ Name/Dose: _____
Name/Dose: _____ Name/Dose: _____
Name/Dose: _____ Name/Dose: _____
Name/Dose: _____ Name/Dose: _____
Name/Dose: _____ Name/Dose: _____
Name/Dose: _____ Name/Dose: _____
Name/Dose: _____ Name/Dose: _____
Name/Dose: _____ Name/Dose: _____
Name/Dose: _____ Name/Dose: _____

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____

Smoking Status:

☐ Current Every Day ☐ Heavy ☐ Light ☐ Current Some Days
☐ Former ☐ Never ☐ Unknown if Ever ☐ I Decline to answer

Please read and sign:

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signiture: _____ Date: _____

MONROE PODIATRY GROUP, PLLC

Raymond DiVasto, D.P.M.
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Telephone: (585) 424-6800
Fax: (585) 424-6517

2800 Spencerport Rd., Suite a6, Spencerport, NY 14559
Telephone: (585) 404-4123
Fax: (585) 280-5166

HIPAA PRIVACY & PAYMENT AUTHORIZATION

HIPAA: *A copy of the HIPAA Privacy Policy is available per your request upon arrival to Monroe Podiatry Group*.

Patient may designate up to three persons with whom they authorize Monroe Podiatry to share their medical information with. If there are no names written down on this form then we can only talk to the patient themselves about their medical information, appointments, billing questions etc.

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

Please list any limitations or special requests for communications: _____

_____

Guarantor information

Guarantor (Responsible Billing Person, POA, Parent, etc.) Name: _____

Street address/Mailing Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Home Phone: _____ Work Phone: _____ Cell: _____

FINANCIAL RESPONSIBILITY:
I the patient agree to pay and guarantee payment in full of any and all charges for services and/or durable medical equipment (DME) provided or to be provided by Monroe Podiatry Group, PLLC and by health care providers who may provide services.

Print Name: _____

Signature of Patient/Beneficiary: _____ Date: _____

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DURABLE MEDICAL EQUIPMENT/SUPPLIES WAIVER FORM

To our patients:

Certain medical conditions may, or may not, require the use of durable medical equipment/supplies, which may include any of the following: pre-fabricated and custom-fabricated casts, splints/braces, dressings, slings, etc. Although these are considered to be "medically necessary" by your physician, many insurance carriers will deny payment of such items.

If you are covered by private insurance, it is our policy to bill your insurance carrier(s) for certain items (please note: many private insurance companies consider pre-fabricated "off the shelf" splints to be non-covered items). In the event that these claims are denied by your insurance carrier(s), you will be held responsible for paying any outstanding bills regarding such items issued. For non-covered items, payment is due when the item is dispensed.

Note: Monroe Podiatry Group has chosen not to be accredited with Centers for Medicare and Medicaid Services (CMS) as a durable medical equipment (DME) provider. As such, we do not have a supplier number and cannot submit Medicare DME claims. You may contact 1-800-633-4227 for instructions on how to submit a claim on your own behalf.

By signing I agree to the above statement.

Patient Name (printed): _____

*Representative, Name: _____ Relation: ☐self ☐spouse ☐child ☐ other

Signature: _____ Today's date: _____