East Point
FOOT & ANKLE

250 N. Main Street Suite 102, East Longmeadow, MA 01028 Phone: 413-525-5200 Fax: 413-525-5700

Thank you for choosing our office for your foot and ankle needs. We greatly appreciate your business. We will ask during your first visit to provide the completed new patient paperwork, a medication list, a photo ID, an insurance card, and if necessary, a parent or guardian if you are under 18 years old.

Please complete all sections of this paperwork

Patient Information

Name:_____

Date of Birth: _____ Language:_____Race/ethnicity:_____

Street Address: _____ City:_____ State:_____ Zip Code: _____

Home phone #:_____ Work phone #: _____ Cell phone #: _____

Email address:_____

Primary Care Physician:_____

Emergency Contact:_____ Phone #_____

Name of Pharmacy:_____

Medical Information

Medical Conditions:_____

_____

_____

Allergies:_____

_____

Surgical History:_____

_____

Family Medical History:_____

_____

_____

Medications:_____

_____

_____

Acknowledgement Receipt of Notice of Privacy Practices (HIPAA)

I acknowledge that I was provided with a copy of the Notice of Privacy and I have read and understood the notice.

Signature of Patient or Parent/Authorized Representative:_____

Date:_____

Information Release to Primary Care Team

I authorize East Point Foot & Ankle, P.C. to release any information acquired in the course of my visits, medical examination, or treatment to my primary care doctor's office.

Signature of Patient or Parent/Authorized Representative:_____

Date:_____

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FINANCIAL POLICY PLEASE READ CAREFULLY!

We appreciate you choosing East Point Foot and Ankle, P.C. for your healthcare needs. The medical services that you have elected to participate In Implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees that are set by CMS guidelines. As a courtesy to you, we will verify that your Insurance Is active and bill your insurance company on your behalf.

It Is your responsibility to understand the policies of your health Insurance plan. This can be very confusing to most, so we have provided some explanations. We are considered specialists on your insurance plan. You will be responsible for any co-payment, deductible, and co-Insurance that Is determined by your contract with your insurance company.

Copay A flat amount you pay up front for a health care visit every appointment. **Ex:** if your specialist copay is $25, you will pay $25 each time you visit the specialist office.	***Deductible*** The amount of money you will pay out of your pocket before your healthcare insurance will start to cover some expenses. **Ex:** If your deductible is $2,500, you will need to spend $2,500 out of your own savings before insurance will start to pay a portion.
Coinsurance The percentage of cost you pay for a service after you have met your deductible. **Ex:** if your coinsurance is 20%, that means you'll pay 20% of the costs of service and your insurance will pay 80% until your out-of-pocket maximum has been met.	***Out-of-pocket Maximum*** The limit to the total number of dollars any one person can spend on their health insurance each year. **Ex:** if your out-of-pocket is $5,000, once you have met this limit for the plan year, your insurance carrier will *finally* pay 100%.

- ✓ **Copay**: Your Copay will be collected at the time of your visit. If you do not pay your copay at the time of your visit, we will add an additional **$25.00** service charge when It Is billed.

- ✓ **Referral**: If your insurance requires a referral to see a specialist from your primary care doctor, it is ***your responsibility*** to get this before the office visit. If we do not have the referral, your insurance will refuse to cover the visit and you will be held responsible for the entire costs. It Is also ***your responsibility*** to know how many visits your referral Is approved for and when it expires. If you use all the visits or your referral has expired, It Is ***your responsibility*** to get a new one.

- ✓ **Non-Covered Insurance Items/Procedures**: Will be paid the day of service and there will be no refund on these products/procedures. Ex: Platelet-Rich-Plasma injections, Extracorporeal Shockwave Therapy, Revitaderm cream.

- ✓ **Durable Medical Equipment (DME):** We dispense crutches, Cast boots, and ankle braces in the office. Insurance policies can be very particular about this type of equipment and most likely will leave you responsible for the cost or some of the cost. Please educate yourself about your policies DME.

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- ✓ **Surgery:** Both physicians are trained surgeons and specialize in numerous reconstructive procedures. A lot of time and details go into booking a surgical case. We will authorize the surgery through your insurance beforehand. We will expect any costs that you are responsible for to be paid the day of your pre-operative visit with the surgeon.

- ✓ **Cancel Surgery:** If you cancel a scheduled surgery, the cancellation fee is $250.00. If you no show your surgery, you will be charged $500.00 and it will not be rescheduled.

- ✓ **Cancellation/no show policy:** Please cancel at least 24 hours in advance of a booked office appointment. If canceled after the 24-hour window, you will be charged $25.00. If you no show the appointment, you will be charged $25.00. If you cancel/no show three times in a row, you will discharged from the practice.

- ✓ **Late Arrival Policy:** If you arrive more than 15 minutes past your scheduled appointment time, you may be asked to reschedule. We take pride on operating on a timely schedule and spending quality time with our patients. One late arrival can change the entire day for the physicians and the other patients. Please be courteous of that.

- ✓ **Returned Check Fee:** There will be an extra $25.00 added to a return check/bounced check.

- ✓ **Account Balances:** Once we submit an office claim to the insurance company it can take up to 3 months for them to send the payments. This means that your statements may come to you long after the actual date of service. We expect all balances on accounts to be paid upfront before any visit or within 30 days of receiving the invoice. Any outstanding balances will need to be paid before booking another appointment. We do our own billing so let any one of us know if you have any questions. We will use a collection agency for any outstanding balances that have not been paid in 90 days or greater.

- ✓ **Medical Records and Radiograph fees:** We will charge a fee to collect your records. $0.25 per page and $1.00 for the xray disc. You can pick the records up In person or we can send via regular mail. We will charge an extra $7.00 to send records via certified mail.

- ✓ **Self-Pay:** We offer self-pay rates for all our medical services. Please feel free to inquire about the pricing. Payment will be due the day of the service/visit.

- ✓ **We accept cash, checks, Visa, MasterCard, American Express, Discover, and Care Credit.**

Authorization of Release of information for insurance claims and statement of financial responsibility

In signing below, you acknowledge that you have read the policies above regarding financial responsibility at East Point Foot and Ankle, P.C. for providing medical services to you or your dependent. You certify to the best of your knowledge that the information above is true and accurate. You authorize the release of necessary medical information to process your insurance claims and assign East Point Foot and Ankle, P.C. all payments from your insurance company for services rendered to you or your dependents. You understand that you are responsible for your copayments, deductible payments, and coinsurance payments as determined by your insurance contract along with any non-covered service payments. All payments will be expected at the time of service.

Patient Signature:_____ Print Name:_____ Date:_____
Parent or Authorized Representative Signature:_____ Print Name:_____ Date:_____

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Authorization for Release of Medical Information

I hereby authorize East Point Foot & Ankle, P.C. to request my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and request a copy of the information described on this form if I ask for it, and that I can request a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above. This will not affect any requests taken prior to submission of the appeal.

Patient name:_____ Date of Birth:_____

Persons/organization to receive the information:_____

The specific information to released/disclosed is specified below:

Complete Medical Record

Or specify one or more of the following:

Operative reports X-rays Imaging Progress Notes Billing Claim Records

Other (please Specify)

I understand that my health information to be released MAY INCLUDE information that is related sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have initialed below.

Initials

Signature of Patient or Representative:_____

Date:_____

***YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT**