East Point
FOOT & ANKLE

Name: Date of Birth: Date:

Medical History Questionnaire

Please circle Y=Yes and N=No if you have a history of:

If you answered yes, please write treatment for condition

Achilles tendonitis/tears	Y	N	_____
Plantar fasciitis	Y	N	_____
Plantar Wart	Y	N	_____
Heel Spur	Y	N	_____
Osteomyelitis	Y	N	_____
Bunions	Y	N	_____
Hammertoes	Y	N	_____
Ingrown toenails	Y	N	_____
Athletes foot	Y	N	_____
Neuromas	Y	N	_____
Toenail fungus	Y	N	_____
Foot/ankle surgery	Y	N	_____
Rheumatoid arthritis	Y	N	_____
Osteoarthritis	Y	N	_____
High Blood pressure	Y	N	_____
High Cholesterol	Y	N	_____
Diabetes	Y	N	_____
Heart Disease	Y	N	_____
Tested + COVID	Y	N	_____

Please turn over to finish completing medical questionnaire

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Medical History Questionnaire

Please circle Y=Yes and N=No if you have a history of:

If you answered yes, please write treatment for condition

COVID vaccine	Y	N	_____
Psoriasis	Y	N	_____
Vitamin D deficiency	Y	N	_____
Skin rashes	Y	N	_____
Back pain	Y	N	_____
Back surgery	Y	N	_____
Neurological disorders	Y	N	_____
Circulation issues	Y	N	_____
Varicose veins	Y	N	_____
Raynaud's	Y	N	_____
Thyroid issues	Y	N	_____
Cancers	Y	N	_____
Inflammatory bowel Disease (Celiacs, Crohn's Ulcerative colitis)	Y	N	_____

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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: _____ Race: _____

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 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

Insurance and Financial Liability

I allow East Point Foot & Ankle, P.C. to bill my insurance company for services rendered if applicable. However, I assume responsibility for any balance if I have provided incorrect, outdated, or invalid insurance information. I will also have an up-to-date copy of my insurance card present at each visit. If coverage cannot be verified at the time of service, I agree to pay in full on the date of service.

Payment

I assume financial responsibility for any and all services not covered by my insurance plan. East Point Foot & Ankle, P.C. will submit a claim on your behalf to your insurance, but there is no guarantee of payment. Please be aware of your insurance coverage benefits. Payments are expected at the time of service. If you default on your account, you may be responsible for all additional fees.

Co-payments

I understand at East Point Foot & Ankle, P.C. is contractually obligated to collect my co-payment. Co-payments are due the day of the appointment per your agreement with your insurance company. If we do not have your co-payment at the time of service, a $5.00 service change may be added to your account.

Referrals

It is my responsibility to obtain necessary referrals; if there is no referral, I will be financially responsible. If you have an HMO policy, it will not cover any services without a valid referral from the primary care physician listed by your insurance company.

Non-Covered Items

I understand payment of products is expected at the time of dispensing. There will be no refunds on these products

Cancellation Notice

I understand a cancellation notice must be provided at least 24 hours in advance of my appointment. Missed appointments or appointments not cancelled within the 24-hour window, may be subject to a fee of $25.00.

Surgery Cancellation Notice

I understand there will be a $50.00 cancellation fee if I cancel a booked surgery. If I do not show for a scheduled surgery, I may be responsible for a $250.00 fee.

Returned Check Fee

I understand that there will be a $25.00 returned check fee on all returned/bounced checks. I further understand that returned checks must be replaced by cash, bank check, credit card, or money order.

Medical Records and X-rays Fees

I understand that a reasonable fee will be charged to obtain copies of my medical records and/or x-rays

Late Arrival Policy

I understand if I arrive more than 15 minutes past my appointment time, I will be asked to reschedule. We ask for you to plan to arrive on time for your appointment. We operate on a timely schedule.

Authorization to Release Information and Pay Benefits

I authorize the release of any medical information necessary to process claims, and assign to East Point Foot & Ankle, P.C. all payments from my insurance companies for services rendered to me or my dependents.

**Our billing department is available by phone or in person if there are questions or financial hardships you need to discuss. Payment Plans may be available and will require an agreement form.

Signature:_____

Patient Name:_____

Date:_____

Parent or Authorized Representative:_____

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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**