Syracuse Podiatry
7075 Manlius Center Road
East Syracuse, NY 13057
(315) 446-FOOT (3668)
FAX: (315) 849-1182
www.syracusepodiatry.org

PATIENT INFORMATION

First Name _____Middle Initial ___ Last Name _____ Suffix ____

Date of Birth_____ Gender ☐M ☐F Social Security#_____-____-____

Address_____City_____ State_____ Zip Code_____

Phone Number (_____)_____ Cell Phone (___)_____Carrier_____

Marital Status: ☐ Single ☐Married ☐Divorced ☐Widowed ☐Other

EMPLOYMENT INFORMATION

Employer_____ Job Title_____

Address_____City_____ State_____Zip Code_____

Phone Number (_____)_____

Employment Status: ☐Full Time ☐Part Time ☐Retired ☐Self Employed ☐

EMERGENCY CONTACT

Name_____Relationship to Patient:_____Phone Number (____)_____

INSURANCE INFORMATION

Primary Policy:

Insurance Carrier_____

ID/Policy Number_____

Name of Policy Holder_____

Date of Birth of Policy Holder_____

Secondary Policy:

InsuranceCarrier_____

ID/Policy Number_____

Name of Policy Holder_____

Date of Birth of Policy Holder_____

VISIT REASON

Why are you seeing the doctor today?_____

Is there pain associated with this condition? ☐Yes ☐No

What causes or aggravates the pain?_____

What works best to relieve the pain?_____

Any additional factors you would like to mention?_____

Whom may we thank for your referral today?_____

Primary care Physician (PCP):_____Date of Last PCPVisit:_____

Pharmacy Information:_____ Location_____

Shoe Size:_____

ALLERGIES

1. Please Indicate all allergies to medications:

☐ **No known Drug Allergies**

Medication	Reaction	Medication	Reaction
_____		_____	
_____		_____	

Other Allergies: ☐ Adhesives ☐Band Aids/Tape ☐Gloves ☐Latex

2. Do you have any complications due to Anesthesia? ☐Yes ☐No Describe_____

MEDICATIONS

Please include prescriptions, over the counter, vitamins and supplements.

- **You may also submit a current medication list, for your convenience.**

Medication	**Dosage**	**Frequency**	**Medication**	**Dosage**	**Frequency**
_____			_____		
_____			_____		
_____			_____		
_____			_____		

Last Flu Vaccination:_____ Pneumonia Vaccination (if >65 yrs old)_____

PAST MEDICAL HISTORY

Please CHECK any conditions that currently apply OR that you have experienced in the past:

Constitutional/General

☐ Cancer/Type_____
☐Elevated Temperature
☐Night Sweats

Cardiovascular

☐ Angina
☐Blood Clots/DVT
☐Easy Bruising/Bleeding
☐Heart Attack
☐Hypertension
☐Irregular Heart Beat
☐Poor Circulation
☐Rheumatic Fever
☐Valve Problems

Respiratory

☐Asthma
☐Chronic Cough
☐COPD
☐Emphysema
☐Shortness Of Breath
☐Sleep Apnea/CPAP

Infectious Disease

☐HIV/AIDS
☐STDs
☐Tuberculosis/TB

Gastrointestinal

☐Acid Reflux/GERD
☐Gall Bladder
☐Hiatal Herna
☐ Irritable Bowel Syndrome
☐Stomach/Bowel Problems
☐Ulcers

Genito-Urinary

☐Bladder or Kidney Stones
☐Infection
☐Kidney Failure ☐Dialysis
☐Prostate Disease

Endocrine

☐Heat or Cold Intolerance
☐Diabetes
☐Hyperthyroid
☐Hypothyroid

Hematologic Disease

☐Anemia Type_____
☐Sickle Cell

Liver

☐Cirrhosis
☐Hepatitis
☐Jaundice

Vision

☐Double/Blurred Vision
☐Glaucoma
☐Hearing Deficit/Loss
☐Hearing Aid
☐Macular Degeneration
☐Vision Changes
☐Contacts/Glasses☐

Nervous System

☐Anxiety
☐Depression
☐Convulsions/Epilepsy
☐Fainting
☐Memory Loss
☐Migraines
☐Muscle Weakness
☐Muscular Dystrophy
☐Muscular Sclerosis
☐Stroke
☐Neuropathy
☐Parkinson's Disease
☐Other:_____
_____
_____
_____

SOCIAL HISTORY

1. Do you currently smoke or chew tobacco? ☐YES ☐NO
How many packs/cans per day?_____ How many years?_____

If NO, have you in the past? ☐YES ☐NO For how many years?_____

2. Do you drink alcohol? ☐YES ☐NO How many glasses/drinks per day?_____

3. Do you drink caffeine ☐YES ☐NO How many cups/drinks per day?_____

4. Do you use any illicit drugs (i.e. marijuana, cocaine, heroin, etc.)? ☐YES ☐NO
If yes, which drugs?_____

If no, have you in the past? ☐YES ☐NO Which drugs?_____

SURGICAL HISTORY

Please List any Surgeries AND Year:

_____
_____
_____
_____
_____

FAMILY HEALTH HISTORY:

Mother:_____
Father:_____
Siblings:_____
Children:_____
Maternal Grandparents:_____
Paternal Grandparents:_____

PATIENT HIPAA ACKNOWLEDGEMENT AND DESGINATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to it's terms.

Name of Patient	Date of Birth	Signature of Patient/Representative	Date

II. Designation of Certain Relatives, Close Friends and/or Caregivers as my Personal Representative:

I agree that the practice may disclose parts of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare and/or payment relating to my healthcare. In that case, the Physician/Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

Print Name:_____ DOB or Other Identifier:_____

Print Name:_____ DOB or Other Identifier:_____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hearby request that the Practice make all communications to me as I have listed below:

Home Telephone Number:

☐Okay to leave a message with detailed information **-OR-** ☐Leave a message with call back number only

Work Telephone Number:

☐Okay to leave a message with detailed information **-OR-** ☐Leave a message with a call back number only

Cell Telephone Number:

☐Okay to leave a message with detailed information **-OR-** ☐Leave a message with call back number only

EMAIL:_____ ☐Okay to email address Practice has on file

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1. The above authorizations are voluntary and I may refuse to their terms without affecting any of my rights to receive healthcare at the Practice.
2. These authorizations may be revoked at any time by notifying the Practice in writing at the Practice's mailing address marked to the attention of "HIPAA Compliance Officer."
3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any recovation.
4. If you request it, a copy of the information described in this form can be obtained at the front desk.
5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction and that I fully understand this authorization form.
6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

IV. Assignment of Benefits:

I hereby assign directly to Dr. Ryan D'Amico, all medical benefits, if any, otherwise payable to me for services rendered. I understand that all services rendered to me (or my dependents) are charged directly to me and I am personally responsible for payment of all charges whether or not paid by insurance. Patient or responsible party agrees to pay any and all costs of collection and/or attorney fees required to settle account. I authorize the use of this signature on all my insurance submissions. I hereby authorize the release of all information necessary to secure the payment of benefits. In order to insure proper follow up and continuity of care, I agree that a copy of my medical records may be released to a designated referral provider and/or physician.

Signature of Patient OR Patient Representative	Date

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Syracuse Podiatry Financial Policy

Thank you for choosing Syracuse Podiatry for your foot and ankle health. We look forward to addressing any foot and/or ankle pain you may experience with the utmost expertise. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part. Please understand that payment of your bill is part of this treatment and care. Listed below, please find our current financial policy:

INSURANCE:

We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with, but do not have an up-to-date insurance card, payment in full for each visit is required, until we are able to verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage and be aware that your insurance benefit is a signed contract between you and your insurance company.

MEDICARE:

We are a participating Medicare provider. We accept Medicare benefit amounts. Medicare, as well as, your secondary insurance (if applicable) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible, if it has not yet been met. You are also responsible for any copayments/coinsurance, which are usually 20% of the allowed amount for a medical item and/or service.

SECONDARY INSURANCE:

Your medical claim will be forwarded to your secondary insurance (if applicable) after payment and/or an explanation of benefits (EOB) has been received from your primary insurance company.

SELF-PAY:

Payment in full is due at the time of service if you are not currently covered under a health insurance plan.

NON-COVERED SERVICES:

Please be aware that some of the services you receive may not be covered or not considered reasonable or medically necessary by Medicare and/or other insurers. You are responsible for full payment of these services at the time of service.

PATIENT BILLING:

ALL co-payments must be paid AT THE TIME OF SERVICE. This arrangement is part of your contract with your insurance company. It is considered insurance fraud if our office fails to collect co-payments from patients at the time of service. Please help us in upholding the law by paying your portion of insurance benefits at each visit. As a courtesy, our office does verify benefits with your insurance carrier; however, the insurance agreement is a contract between you and your insurance carrier. It is recommended that you verify your benefits with your carrier as well. **Failure to pay your co-payment at the time of your visit will result in a $5.00 billing surcharge.** Additionally, bounced checks will be the responsibility of the patient and an addition fee (bank fee) of $30.00 will be added if a check should bounce. For any questions or concerns, please call our office and ask to speak to

our practice administrator, Dawn.

REFERRALS/AUTHORIZATIONS/Requested documents:

Our office is required to follow the guidelines of your managed care plan, which mandates that upon visiting a specialist, such as ours, you must have a referral from your primary care physician (PCP) prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of visit. Please find listed below some insurance examples which will require a referral and/or authorization at the time of service:

A. Blue Cross Blue Shield: Plans which begin with "VYB" or "VYT" -- requires Referral from PCP

B. Onondaga Nation Health Insurance -- requires a Referral be presented at **each** visit

As per NYS law a $0.75 charge per page will be the patient's responsibility.

NON-CUSTOM DURABLE MEDICAL EQUIPMENT (DME) RETURNS:

If a patient is unsatisfied with any non-custom Durable Medical Equipment item, it must be returned within 30 days, as per Medicare guidelines. Returns after 30 days will not be permitted. The item will only be accepted as a return if it is in returnable condition; which is subject to consideration. ***Any custom Durable Medical Equipment item may not be returned for any reason.***

PATIENT CANCELLATION AGREEMENT:

Our office requires twenty-four (24) hour notice for all patients canceling and/or rescheduling office visits. If our office does not receive twenty-four (24) hour notice you will be charged a $50.00 fee for the missed office visit. If you miss two (2) or more visits, it is per our office policy to discharge the patient from our practice, therefore, the patient is no longer able to schedule at our office. If you arrive over twenty (20) minutes late to your scheduled appointment, we may need to reschedule your appointment. You will bear complete financial responsibility for any fee(s) incurred.

ASSIGNMENT OF BENEFITS:

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Syracuse Podiatry all insurance benefits payable to me for services rendered. I understand that I am responsible for payment of co-payments, non-covered services, and other fees AT THE TIME OF SERVICE. I hereby authorize Syracuse Podiatry to release all of the information necessary to secure payment of benefits. I authorize Release of Medical information to my insurance carrier, or requested physician, to provide continuity of care. I authorize the use of this signature on all insurance submissions. I understand that is it my responsibility to inform Syracuse Podiatry if there are any changes in my health insurance information and acknowledge I was provided with and/or offered a copy of the Notice of Privacy Practices and understand and accept it's terms.

_____	_____	_____
Print Name	Signature	Date

OR

_____	_____	_____	_____
Financially Responsible Party	Relation	Signature	Date