PORTSMOUTH Foot and Ankle

14 Manchester Square, Suite 250, Portsmouth, NH 03801
Phone: 603-431-6070
17 Riverside Street, Suite 205, Nashua, NH 03062
Phone: 603-882-8866

Welcome! We are happy to have you join our office as a new patient. Thank you for choosing Portsmouth Foot and Ankle for your podiatric needs. We understand there are many choices to provide your podiatric care and we greatly appreciate your business.

We ask that you please take a minute to review and complete your new patient paperwork ahead of time. *Please do not arrive at your scheduled time without paperwork completed*. If you do not bring completed paperwork to your first appointment you are expected to arrive 15 minutes early.

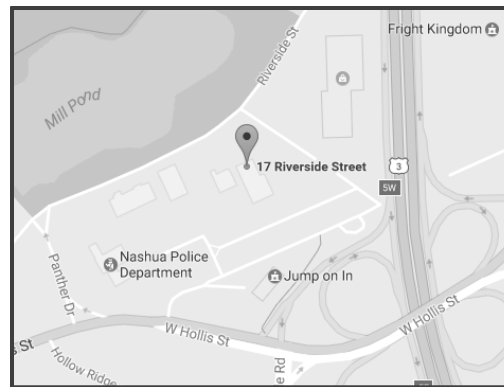
WHAT TO BRING TO YOUR FIRST APPOINTMENT

- Completed Paperwork
- Medication List (We will be happy to photocopy it for your file)
- Photo ID
- Insurance Card
- Parent or Guardian if you are under 18-years of age (or a completed consent form available on our website)

Our office is extremely efficient and runs on schedule. We take pride in the fact that we are punctual and our patients really appreciate being seen promptly. However, being punctual does not allow us much flexibility. Due to our commitment to staying on schedule, we are not able to see patients who arrive more than **10 minutes late.** Patients arriving beyond the 10 minute cut off will be rescheduled. If you are running late please give us a call. If there is an opportunity to still have you be seen we will advise you to still come to your appointment.

If you are unable to make an appointment with us, it is important that you call the office as soon as possible so we can make other arrangements. If you do not cancel or reschedule 24-hours (or more) in advance you will be assessed a $25 fee.

PORTSMOUTH: We are located on Pease International Tradeport. We are in the "International Marketplace" building, which is across from Great Bay Kids Company. We are located on the 2nd floor near the elevator in Suite 250.



NASHUA: We are located on the second floor, Suite 205, at 17 Riverside Street

Feel free to contact us at anytime with questions or concerns regarding your care, treatment or products and services we offer here at Portsmouth Foot and Ankle. *We look forward to seeing you soon!*

PORTSMOUTH Foot and Ankle

Date:____________________ ***PLEASE COMPLETE ALL SECTIONS OF THIS PAGE***

Patient Information:

Name: (Last, First, Middle)____ ________________________

Street Address: ____City: ________________________ State: ____ Zip code: ________

Home #:___________________ Work #: __________________ Cell #:_________________ Preferred phone number:__________

Birthdate: ___________ Gender: __________ SSN: ________________ Email: ____

Ethnicity: _____________ Primary language: _________________ Marital status:__________________ Student: Y or N

Primary Care Physician: _________________________ Office phone # (___) _____________________ Date last visit:__________

Referring Physician: ____________________________ Office phone # (___) _____________________ Date last visit: _________

Employer: ___________________________ Occupation: _______________________ Spouse: ________________________

Emergency Contact & phone #: ____________________________ Legal representative (if minor): _________________________

Parent/Guardian: __________________ Date of Birth: _____________**E-Mail:**____

Preferred contact method: □Home phone □ Cell Phone □ E-Mail OK to leave appointment message: **Y / N**

____**Phone calls:** Our office provides a courtesy call to confirm upcoming appointments for patients who DO NOT use our automated reminder system. **(Personal medical information will not be left on a machine)**
Is it okay for us to leave a reminder message on your answering machine? YES______ NO______

To Use Our Automated Text Message & E-Mail Reminder System You Must Provide Your E-mail & Cell Phone!

Insurance Information:

Primary Insurance __________________ Secondary Insurance _____________________ Tertiary Insurance __________________

Insurance Subscriber Name: ____DOB:____________SS#________________________

Responsible Party:____DOB:___________Relationship:______________________

Street: ____City: ______________________ State:_____Zip:___________________

How did you find out about us?- *please provide as much detail as you can*

□ Doctor's Office/Referral □ Our Website □ Internet/Search (circle one):Google Yahoo Bing Yelp

□ Family/Friend_________________ □ Newspaper □ Other Source: ______________________________

□ Phonebook □ Coupon/Promotion □Foot Card/Patient of Ours (Name?)

□ Insurance □ Social Media □ Mailing/Post Card __________________________________

<u>Disclosure Health Information</u>(Only complete if you are authorizing someone else access to your medical information)

___ **Information release to PCP**: I authorize Portsmouth Foot and Ankle to release any information acquired in the course of taking the medical history, the medical examination or treatment to my primary care doctor's office for insurance claim filing.

<u>AUTHORIZATION FOR RELEASE OF INFORMATION</u>:
I hereby authorize **Portsmouth Foot and Ankle** or staff to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization and may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient name: ____ Date of birth: ___________________________

Persons / organizations to receive the information if requested:

____

I understand that this authorization will remain in effect until rescinded in writing by the undersigned.

____

Signature of patient or patient representative:____Date:___________________

Printed name of patient representative & relationship to patient:

____

Portsmouth Foot and Ankle

ACKNOWLEDGMENTOFRECEIPT OF
NOTICEOF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

____ ______________________________
Patient Name (please print) Date

____
Parent or Authorized Representative (if applicable)

____
Signature

FINANCIAL POLICY

Insurance and Financial Liability: I allow Portsmouth Foot and Ankle to bill my medical insurance company for all services rendered. 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.

Payment: I assume financial responsibility for any and all services not covered by my insurance plan. Portsmouth Foot and Ankle will bill your insurance but there is no guarantee of payment. It is your insurance, and, therefore, you should be aware of your coverage benefits. If you default on your account, you may be held responsible for all additional fees. Payments are expected at the time of service.

Co-payments: I understand that Portsmouth Foot and Ankle is contractually obligated to collect my co-pay. Co-payments are due day of appointment per your insurance. If we do not have your co-pay at the time of service, a $5.00 service fee will be charged 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 as listed by your insurance.

Non-Covered Items: I understand payment for products is expected at the time of dispensing. There will be no refunds on these products.

Cancellation Notice: I understand cancellation notice must be provided at least 24 hours in advance of my appointment. Missed appointments or appointments not cancelled in that time period may be billed at the rate of $25.00.

Surgery Cancellation Notice: I understand there will be a $50.00 cancellation fee if I cancel a booked surgery.

Returned Check Fee: I understand that there will be a $25.00 returned check fee on all returned checks.

Late Arrival Policy: I understand if I arrive more than 10 minutes past my appointed 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 and do not wish to keep anyone waiting.

Authorization to Pay Benefits: I authorize my insurance company to release payment of medical benefits to Portsmouth Foot and Ankle for services rendered to me by this office.

** Our billing manager is available at time of appointment or by phone if there are any questions or financial hardships you need to discuss. Please do not hesitate to call.

The above is to remain in force until rescinded in writing by the undersigned:

Signature: ____

Patient Name: ____Date: _________________________

Parent or Authorized Representative: _______________________________Relationship ____________

We reserve the right to petition the IRS under Section 7623 Debtor Intervention of the Revenue Code.

PORTSMOUTH Foot and Ankle

Patient Name: ____________________ DOB: ______________

Patient Medical History

List medications you are currently taking (including non-prescription and vitamins)

____
____
____
____
____
____
____
____
____

List allergies& reaction:

____
____
____

List Surgeries:

____
____
____

Circle below any or all that pertain to your medical history:

Ulcers
Kidney
Liver
Lungs
Thyroid
Communicable diseases
Heart
Gout
Phlebitis
Diabetes
High blood pressure
Stomach
Intestine
Urinary
Asthma
TB

Sickle cell
Transfusions
Circulation
Cancer _________
Seizures
Stroke
Fainting
Hepatitis
Anemia
Substance abuse
Bleeding
Arthritis
Depression
Social alcohol use
Rheumatic fever

Other: ______________________________

Other: ______________________________

Height: _____ Weight: _______ Shoe size: _____ Flu Vaccine past flu season?: Y/N <u>Over 65 only:</u> Pneumonia Vaccine: Y/N

Current Tobacco use: Yes or No (circle one) Past Tobacco use Yes or No (circle one)

Pregnant: Yes or No (circle one) Nursing: Yes or No (circle one)

Pertinent family medical history:

____

____

I am here today for: *(Please circle all that apply)*

1. Abnormal shoe wear
2. Ankle fracture or injury
3. Arthritis
4. Biomechanical/gait evaluation
5. Bunion
6. Deformed joints
7. Diabetes check
8. Evaluation of child's feet
9. Foot fracture or injury
10. Hammertoes
11. Heel pain
12. Ingrown Toenail
13. Knee or back pain
14. Nail problem
15. Nerve pain
16. Pain / fatigue in feet
17. Poor circulation
18. Prescription orthotics
19. Running/sports injury
20. Second opinion
21. Shin splints / tendonitis
22. Skin problem
23. Sprain of ankle / foot
24. Surgery evaluation
25. Toe fracture / injury
26. Warts
27. Other ___________

Billing Options:

At Portsmouth Foot & Ankle, we request to keep your credit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. This will be used for any deductibles, co-insurance amounts, co-pays or balance not paid at the time of service. At the checkout counter you may pay by cash, check or a card of your choice.

If you would prefer to be billed by mail simply initial here _________

If you would like us to keep your credit card on file and authorize us to use it for balances please fill out the form below:

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. You will be given a courtesy call prior to any charges being processed.

I authorize Portsmouth Foot & Ankle to charge the portion of my bill that is my financial responsibility to the following credit or debit card:
Select: □Visa □Mastercard □Discover □AMEX □Care Credit

Credit Card Number ____

Expiration Date _____ / _____ CVC___________

Cardholder Name ____

Signature ____

Billing Address ____

City ______________________ State_______ Zip ___________

I (we), the undersigned, understand the above, and authorize and request Portsmouth Foot & Ankle to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Portsmouth Foot & Ankle. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Portsmouth Foot & Ankle in writing and the account must be in good standing.

Patient Name (Print): ____

Patient Signature: ______________________________________ Date: _____ / _____ / _____