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 Northeast 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 at 14 Manchester Sq. We are located on the 2nd floor near the elevator.

Nashua:
We are located on the 2nd floor of Riverside Medical at 17 Riverside St. Suite 205

Please feel free to contact us anytime with questions or concerns regarding your care, treatment or products and services we offer here at Northeast Foot and ankle.

We look forward to seeing you soon!

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

Patient Information:

Name: (Last, First, Middle)_____Date of Birth _____

Street Address: _____City: _____ State: ____ Zip Code: _____

Home #:_____ Work #: _____ Cell #:_____ Email: _____

Preferred contact method: ☐Home phone ☐ Cell Phone ☐ E-Mail OK to leave appointment message: (Y) / (N)

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

Gender: _____ SSN: _____ Employer: _____ Occupation: _____

Primary Care Physician: _____ Office phone # (___) _____ Date last visit:_____

Spouse/Emergency Contact: : _____ Phone: _____

Parent/Guardian/Legal representative: _____ Date of Birth: _____ Phone:_____

Street Address: _____City: _____ State:_____Zip Code:_____

Insurance Information:

Primary Insurance Name_____ Secondary Insurance Name _____

Insurance Subscriber Name: _____DOB:_____SSN:_____

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

☐ Doctor's Office/Referral_____ ☐ Family/Friend_____

☐ Our Website ☐ Social Media ☐ Internet/Search (circle one): ◯Google ◯Yahoo ◯Bing ◯Yelp

☐ Mailing/Post Card/Coupon/Promotion ☐Foot Card/Patient of Ours (Name?)_____ ☐ Other Source:

_____

ACKNOWLEDGMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

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.

Signature of Patient or Parent/Authorized Representative: _____ Date: _____

FINANCIAL POLICY

Insurance and Financial Liability: I allow Northeast 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. 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. Northeast Foot and Ankle 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 held responsible for all additional fees.

Co-payments: I understand that Northeast Foot and Ankle is contractually obligated to collect my co-payment. Co-payments are due the day of 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 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 company.

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. I further understand that returned checks must be replaced, including the fee, by cash, bank check, or money order.

Medical Records and X-Ray 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 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 Release Information & Pay Benefits: I authorize the release of any medical information necessary to process claims, and assign to Northeast Foot and Ankle all payments from my insurance companies for services rendered to me or my dependents.

** Our billing department 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. Payment plans may be available and will require an agreement form.

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.*

Patient Name: _____ **Date of birth:** _____

Medications
(please include non-prescriptions and vitamins)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies and Reactions

_____
_____
_____
_____
_____

Family Medical History

_____
_____
_____

Circle any that pertain to your medical history

- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer (Type: _____)
- ☐ Circulation Issues
- ☐ Communicable diseases
- ☐ Diabetes
- ☐ Fainting
- ☐ Gout
- ☐ Heart Issues/Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease/Hepatitis
- ☐ Lung Issues
- ☐ Seizures
- ☐ Sickle Cell
- ☐ Stomach Issues/GERD
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Issues
- ☐ Ulcers
- ☐ Urinary Issues
- ☐ Other:_____

_____
_____

Past Surgical Procedures

_____
_____
_____
_____
_____
_____

Cigarette/Tobacco Use

◯ Never ◯ Former Smoker ◯ Current Smoker

Pneumonia Vaccine **(over 65 years old only)** (Y) (N)

Pregnant: (Y) **(N)** (circle one) Nursing: (Y) **(N)** (circle one)

Name of Pharmacy and location

_____

Height: _____ Weight: _____ Shoe size: _____

Flu Vaccine past flu season? (Y) (N)

What brings you into our office today? _____

What are your goals of today's visit? _____

Information release to PCP: I authorize Northeast 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.

Signature: _____ Date _____