ROCHESTER PODIATRY

Board Certified Physicians and Surgeons

Massimo Pietrantoni, DPM, FACFAS ◆ Michael Daniels, DPM, DABPM

Date of Appointment _____ When did your foot /ankle issue start? _____

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Sex ☐ M ☐ F Birthdate _____

Home Phone ( ) Cell ( ) Work ( )

Emergency, Contact: _____ Relationship to patient? _____ Phone #: ( ) _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separate ☐ Partnered ☐ Minor

Occupation _____ Employer & address _____

Spouse/Partner Info: Name: _____

Occupation: _____ Birthdate: _____

How did you hear about our office? ___ Internet ___ Urgent Care ___ Primary Physician ___ Other _____

Primary Care Physician: _____ Date of Last Visit: _____

Address: _____ Phone #: ( ) _____

Primary Physician's Hospital Affiliation: ____ RRH ____ URMC ____ Other _____

Preferred Pharmacy: _____ Phone #: ( ) _____

Address: _____

Do you need Antibiotics before Surgery/Dental Procedures? _____ Yes _____ No

Reason for today's visit:

Insurance Assignment and Release

I certify that I have insurance coverage with my insurance company (ies) and assign Rochester Podiatry and its healthcare providers all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Rochester Podiatry may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

_____ _____

Signature of Patient or Guardian Date

Medications: ____ NONE

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Surgeries: ____ NONE

_____ _____

_____ _____

_____ _____

Allergies: ____ NONE

__ Adhesive/ tape
__ Anticoagulant Therapy
__ Aspirin
__ Codeine
__ Demerol
__Iodine
__ OTHER _____
_____
_____

__ Latex
__ Local Anesthetics
__ Penicillin
__ Metal/Nickel
__ Seafood
__Sulfa

Height _____ Weight _____
Shoe Size _____
Have you seen a Podiatrist in the past?
Yes No
If Yes, Please List:
Name _____
Last Visit _____
Reason _____
_____

Social History:
Tobacco ___ Yes ___ No
Alcohol ___ Yes ___ No
Coffee/tea ___ Yes ___ No
Recreational drugs ___ Yes ___ No
I.V. Drugs ___ Yes ___ No
OTHER ___ Yes ___ No
_____
_____

Family History: M= Mother F= Father
Heart Disease ___ Yes ___ No
Stroke ___ Yes ___ No
Diabetes ___ Yes ___ No
Gout ___ Yes ___ No
Cancer ___ Yes ___ No
Sickle Cell ___ Yes ___ No
Rheumatoid Arthritis ___ Yes ___ No
Psoriasis ___ Yes ___ No
Other _____

PODIATRIC HISTORY

	Currently	Previously
Ankle Pain	___	___
Athlete's Foot	___	___
Bunions	___	___
Corns, Calluses	___	___
Numbness feet/legs	___	___
Flat feet	___	___
Use over the counter inserts	___	___
Use Custom orthotics	___	___
Heel Pain	___	___
Ingrown toenails	___	___
Plantar warts	___	___
Foot Ulcers	___	___

MEDICAL HISTORY

	Yes	No
AIDS/HIV	___	___
Anemia	___	___
Type _____		
Angina	___	___
Arthritis	___	___
Type_____		
Artificial heart valves	___	___
Asthma	___	___
Back Problems	___	___
Bleeding Disorders	___	___
Cancer	___	___
Type _____		
Chemical Dependency	___	___
Chest Pain	___	___
Cholesterol	___	___
Circulatory Issues (PVD)	___	___
Diabetes	___	___
_____ Type I ____Type II _____ Other		
_____ Use Insulin		
_____ Use Pills		

	Yes	No
Ear Problems	___	___
Eye Problems	___	___
Gout	___	___
Heart Disease	___	___
Hepatitis	___	___
Type _____ What Year _____		
Jaundice	___	___
High Blood Pressure	___	___
Implants	___	___
Type _____		
Kidney Problems	___	___
Liver Disease	___	___
Low Blood Pressure	___	___
Low Back Disc/Nerve Injury	___	___
M.S. (Multiple Sclerosis)	___	___
Neuropathy/Numbness	___	___
Phlebitis	___	___
Prior Blood Clots/DVT	___	___
Psoriasis	___	___

	Yes	No
Psychiatric Care	___	___
Rash/Dermatitis	___	___
Respiratory/Lung Disease	___	___
Rheumatoid Arthritis	___	___
Scleroderma	___	___
Sinus Problems	___	___
Special Diet	___	___
Stroke	___	___
Swollen Neck Glands	___	___
Thyroid Disease	___	___
Tuberculosis (TB)	___	___
Ulcers (Stomach/G.I)	___	___
Unexplained Weight Loss	___	___
Varicose Veins	___	___
Venereal Disease	___	___
Type_____		
Other: _____		

Are you now, or have you been under the care of any doctor (other than your primary care physician) for any reason over the last two years? ___ Yes ___ No If yes, Who & reason? _____

_____

TREATMENT CONSENT

I hereby consent and give my permission to Rochester Podiatry, its healthcare providers, assistants and/or designated replacement to administer and perform such procedures and treatments upon me as the they deem necessary.

Signature of Patient or Guardian: _____ Date: _____

Please Print name of Patient or Guardian: _____ Relationship to Patient: _____

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Financial Policy

At Rochester Podiatry we understand the complicated nature of Insurance coverage and overall cost of health care. In order to provide all of our patients with the best experience with our practice, please read this financial policy in advance of your appointment and contact us with any questions. **585.424.2420**

- Insurance coverage varies from plan to plan, please make sure you call your insurance company regarding your specific coverage, especially if you are looking to receive Custom Shoes or Orthotics.
- All Payments are due at the time of your appointment. (This includes any amounts that are not covered by your health insurance, i.e. co-payments, deductible, or non-covered services)
- Should a service not be covered in full by your insurance company, you acknowledge under this agreement that you will take responsibility to cover the full cost of the services provided to you.
- Please ensure that you have obtained the appropriate referral number from your insurance company, if your coverage requires you to have one. If your plan requires a referral number and you do not obtain one prior to your appointment, any charges that are not covered will be your responsibility.
- Due to the high cost of billing patients for unpaid balances:
    - There will be a $25.00 surcharge if a co-payment is not paid for on the date of service.
    - If a payment is not made within 30 days of receiving a billing statement, there will be a $20.00 late fee added to your bill.
    - We are hopeful that everyone will make arrangements to cover the cost of their services; however, if payment is not being made and we must send your account to a collection agency, there is a charge of 33% of the unpaid balance to cover the cost of the collections process. You acknowledge that you are responsible for these fees as well as any attorney or court fees incurred in efforts to collect payment.
- Due to bank fees, any returned checks will incur a $50.00 charge
- We provide interpreters for those who need one during their visit. We are happy to cover the cost of this service; however, should you fail to show for your appointment, without 24-hour notice, the fee we incur will become your responsibility.

- All appointments require 24-hour cancelation. This allows us to continue to accommodate all patients in the time frame they deserve. If you do not notify us that you cannot make your appointment and do not show for your appointment, you will still be responsible for the payment of the appointment. The charges are as follows:
    - $75 for a regular appointment.
    - $150 for Orthotic casting, procedures, or Comprehensive Diabetic Foot Exams (CDFE)

- We are happy to provide you with copies of your medical records. The cost of this services is:
    - $1.00 per page for copies of paper documents in your chart.
    - $10.00 for a copy of your X-rays on any given date of service.

We understand that there can be extenuating circumstances and we are committed to providing you with exceptional podiatry care and the best possible experience overall. Please notify us of any financial concerns you may have. We also participate with Carecredit to assist patients with the payment process. Carecredit is similar to a credit card but is exclusive to health care needs for the entire family, including pets! This program provides promotional periods of 6, 12, 18 or even 24 months with zero interest to help people with high deductible plans or items that are not covered by insurance. If you have any questions about this program or anything at all, please do not hesitate to contact us, so that we may better assist you, **585.424.2420**. We look forward to caring for all of your foot and ankle needs.

I acknowledge receipt of this policy and agree to abide by the provisions listed above.

Print Name_____

Sign Name_____ Date: _____

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Health Privacy Act

(Typed Policy at Front Desk for your review)

I, _____, hereby acknowledge receipt of Rochester Podiatry LLP's Notice of Privacy Practices. Rochester Podiatry LLP will use or disclose my PHI for the purposes of carrying out treatment, payment and health care operations. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand Rochester Podiatry LLP has reserved a right to change its privacy practices that are described in the Notice. I also understand a copy of any Revised Notice will be provided to me or made available at my next office visit.

I give my consent for Rochester Podiatry LLP to communicate with me via digital methods such as Text messages or Emails as well as leave me messages at the number I have provided.

I give my consent for Rochester Podiatry LLP to notify me of new facilities or services. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Rochester Podiatry LLP.

Signed: _____ Date: _____.
If you are not the patient, please specify your relationship to the patient _____.

I make the following special request for confidential communications: _____
_____
_____

1. Name: _____ Phone: _____ Relationship: _____
2. Name: _____ Phone: _____ Relationship: _____
3. Name: _____ Phone: _____ Relationship: _____

Brighton
382 White Spruce Blvd. ◆ Rochester, NY 14623
(585) 424-2420

Greece
2890 Deway Ave. ◆ Rochester, NY 14616
(585) 663-1370

www.RochesterPodiatryLLP.com