

Welcome To Westside Podiatry Center

Patient Information:

Name _____ Date _____

Address _____ City/State _____ Zip _____

Home # _____ Work # _____ Cell# _____

Social Security # _____ Date of Birth _____ Age _____

Gender: M F Marital Status: S M D W Spouse _____

Employer _____ Address _____

Occupation _____

Family Doctor's Name _____ Phone# _____

Address _____

Insurance Information:

Primary Insurance _____ ID # _____ Group # _____

Secondary Insurance _____ ID # _____ Group # _____

Subscriber Information:

Name _____ Date of Birth _____

Social Security # _____ Relationship to Patient _____

Employer _____ Phone # _____

Emergency Contact: (Someone who is not living with you)

Name: _____ Phone # _____

Whom May We Thank For Referring You? _____

Please be advised that our office has a 24 hr. cancellation policy. Failure to notify our office if you are unable to keep your appointment will result in a fee of \$50 for new patients, and \$30 for established patients.

I authorize Dr. Farrell, Dr. Rounds, Dr. Wadie, and/or Dr. Smith to provide any insurance company, claim administrator, and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits. I hereby authorize payment directly to Dr. Farrell, Dr. Rounds, Dr. Wadie, and/or Dr. Smith of the benefits otherwise payable to me. Also I hereby give permission to Dr. Farrell, Dr. Rounds, Dr. Wadie, and/or Dr. Smith and their assistants to diagnose, administer medications, and perform such procedures as may be deemed necessary in the diagnosis/treatment of my feet and related conditions. I understand and agree that because of human variance and response it is not possible to warrant the outcome of any medical care or service.

Responsible Party Signature _____

Relationship _____ Date _____

Name _____ Birthdate ____/____/____ Appointment Date _____

Height _____ Weight _____
(to be filled out by nurse): BP _____ Pulse _____ Respiration _____
Shoe size _____

Reason for visit: (Be Specific)

Date of onset _____

Medical Doctor _____ Date last seen _____

Doctor treating for Diabetes _____ Date last seen _____

Former Podiatrist _____

Medical History (Circle only those items that apply)

Diabetes- diet/oral/insulin __ years?	Skin problems, psoriasis
Kidney disease	Gout
Anemia	Fibromyalgia
Peripheral vascular dis.	Fainting/Seizures
Arthritis , Rheumatoid, osteoarthritis, Lupus Neuropathy	
Liver disease, hepatitis, jaundice	Anxiety
High blood pressure	Depression
GI Ulcers, Stomach problems	Broken bones in feet or legs
Blood disease, bleeding disorder	Artificial heart valves or joints
Cancer	Chemical dependency
Heart disease, angina , chest pain	Weight loss or gain
Varicose veins	Back problems , herniation of discs / stenosis
Epilepsy,	Circulation problems
Hypothyroidism , Thyroid problems	Chronic diarrhea
Autoimmune disease, HIV, AIDS	MS
Rheumatic fever	CVA (stroke)
Asthma, emphasema, lung problems	High cholesterol
Eye pathology	Leg cramps/numbness
Charcot joint	Neuropathy
Gastric reflux, hiatal hernia	
Other Medical problems (please list): _____	

Surgical History (circle only those items that apply)

Foot Surgery: Type _____ Date: ____/____/____ RT/LT (Please Circle)

Angioplasty	D and C	Hip/knee replacement
Knee replacement	Arterial by-pass	Appendectomy
C-section	Venous ligation	Mastectomy
Cataract	Open heart	Kidney stone
Carotid artery	Back surgery	Kidney removal
Gall bladder	Back surgery	Pacemaker
Tonsillectomy	Prostate	Heart by-pass
Hysterectomy	Breast biopsy/lumpectomy	NONE

Patient Name: _____ Date: _____

Other Surgical History (please list):

Medications (please list, including non-prescription medications)

No current medications _____

Family History (please circle if positive)

	Arthritis	Diabetes	Heart disease	Cancer	High blood Pressure
Mother	yes	yes	yes	yes	yes
Father	yes	yes	yes	yes	yes
Siblings	yes	yes	yes	yes	yes

Social History (please check)

Alcohol _____

Tobacco _____ #packs per day? Caffeine (coffee, tea, soda) _____ #cups per day?

Recreational Drugs _____

Activities _____

Allergies (please circle)

No known drug allergies

Novocain

Iodine

Aspirin

Neosporin

Codeine

Motrin/advil

Penicillin

Cortisone

Adhesive tape

Sulfa

Latex

Other _____

Review of systems (filled out by nurse)

Cardiovascular hypertension / murmurs / chest pain / edema / claudication / ulceration / phlebitis

ENT difficulty swallowing / hoarseness / hearing loss / infection / ringing in the ear /
nose bleed / ear aches / sores

Gastrointestinal jaundice / cirrhosis / hepatitis / abnormal stool

HE dizziness / fainting / headaches / double vision / infection

Mental status alert and oriented / alert but not oriented / confused / lethargic

Musculoskeletal joint pain / joint swelling / muscle pain / poststatic dyskinesia / weakness / back
pain

Neurologic paralysis / stroke / tics / tremors / seizures

Respiratory asthma / bronchitis / difficulty breathing / shortness of breath / vomiting blood
/ emphysema

Tech: _____

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**ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF 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)

Parent or Authorized Representative (if applicable)

AUTHORIZATION TO RELEASE INFORMATION

I authorize the following individuals to have access to my "Protected Health Information."
Please list names:

I give permission for Westside Podiatry when leaving messages to identify that you are calling from Westside Podiatry.

Yes _____

No _____

Signature: _____ **Date:** _____

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Financial Policy

Welcome to Westside Podiatry Center. It is our goal to provide you with excellent care not only medically but in all other aspects as well. Should you receive a bill from us that you do not understand or feel that you may have received in error, please call our billing office promptly at 315-857-0141. The billing office is open Tuesday through Friday from 8 am to 5 pm.

Traditional Medicare Insurance:

Our office participates with Medicare. This means that we will send your claim to Medicare and we will adhere to Medicare's allowable fee schedule. Medicare sets an allowable fee for each service that they cover. Once you have met your annual deductible Medicare will pay us 80% of the allowable fee and you will be responsible for the remaining 20%. If you have a secondary insurance this amount will then be sent on to them and you will be billed for any remaining balance after their payment.

Medicare has strict guidelines concerning their coverage of routine foot care such as trimming nails, or paring corns and calluses. The doctor will be able to determine if your routine foot care is or is NOT covered by Medicare. Should you have a non-covered service such as this performed, you will be asked to pay for that service at the time of your appointment. We will also ask you to sign Medicare's Advanced Beneficiary Notice (ABN) indicating you were informed that Medicare will not be paying for that particular service. We will give you a copy of the ABN for your records. **If you have any other service such as a new patient office visit or a visit for a new problem performed on the same day as routine nail care or another non-covered service**, Medicare will be billed for the covered service **and** we will collect the uncovered service fee from you that day as well.

All Other Insurances including Medicare Replacement Plans:

Westside Podiatry Center accepts **Medicaid** only when it is a **secondary** insurance. We do not participate with most managed Medicaid plans such as Total Care or Fidelis. With this exception, as a courtesy to our patients we will submit your claims to all other insurance companies **providing:**

- At each visit we receive a copy of all current insurance identification cards.
- Our Patient Information Form is current and correctly completed.
- Our Financial Policy is signed.

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If we have not heard from your secondary insurance within 60 days, you will be billed directly. In that event you must contact the insurance company directly to find out why your claim has not been paid.

It is the patient's responsibility to give us their current insurance information. If we do not have a copy of your current insurance card, or have received incorrect or old insurance information, all charges will become the patient's responsibility.

All co-pays and co-insurances are due at the time of your appointment, as specified in your insurance contract and mandated by your carrier in our participating provider agreement.

- We ask that when you arrive for your appointment you are prepared to pay your co-pay. There will be a **\$10 fee** added to your account for **each** unpaid co-pay that is billed to you at your residence. This is applied to your personal balance only and is not submitted to your insurance.
- For your convenience Westside Podiatry Center accepts cash, money orders, MasterCard, Visa and personal checks. **Payment is expected at each visit.** We reserve the right to reschedule your appointment if you are unprepared to pay your co-pay, co-insurance or unpaid balance.
- You will receive a billing statement for all personal balances due. If we have not received a response from you by phone or received a payment or letter regarding your unpaid balance within 30 days, your account will be charged an interest rate of 1.5% per month thereafter. There is a \$25 fee assessed for returned checks.
- Westside Podiatry Center understands that temporary and unexpected financial problems do arise. We encourage you to contact the billing office at 857-0141 immediately for assistance in managing your account.
- If you have a substantial deductible with your insurance policy, you may be requested to pay a percentage of the day's charges at the time of service. If you want to schedule surgery, a percentage of the deductible may be due **before** the surgery is scheduled.

No Insurance:

If you do not have health insurance, charges for the day's medical service **are due at the time of service** unless other arrangements have been made with the billing department in

5415 W. Genesee St. #203
Camillus, NY 13031
(315) 701-3348

27 Fennell Street
Skaneateles, NY 13152
(315) 685-3338

8132 B Oswego Rd.
Liverpool, NY 13090
(315) 546-0285

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advance. In many cases a cash payment discount may be given to patients without health insurance.

Referrals/Authorizations:

It is the **patient's responsibility** to obtain all referrals if your insurance requires one. We will do all we can to assist you, but it is ultimately your responsibility. If a required referral is **NOT** in place **PRIOR to your appointment**, we may **reschedule** the appointment until it is received.

Disability Forms:

The doctors at Westside Podiatry Center will complete your first insurance disability form for you at **no charge**. You will be charged a fee of **\$5.00** for every disability form to be completed thereafter. The fee is payable **upon presentation** of the forms. The forms will **NOT** be completed until the \$5.00 fee is received.

Missed Appointment Policy:

Westside Podiatry Center reserves the right to charge a patient for a missed appointment. If you cannot make your scheduled appointment, you should give us 24 hours notice. A charge for a missed appointment is NOT a charge for the service itself. One missed appointment, or severe weather problems will NOT result in a patient being charged. Consecutive missed appointments, or repeated missed appointments will be assessed At a fee of \$25 for each missed appointment. Habitually missed appointments could lead to a patient being discharged from the practice.

Collections:

Westside Podiatry Center will make every attempt to make payment terms that meet your needs. If we do not hear from you by phone, mail or partial payment within 45 days of a statement being sent, you may be referred to a collection agency. In the event your account is assigned to collection, the patient agrees to be responsible for a 25% collection fee, as well as all court costs and attorney fees. The patient further agrees to pay 1.5% interest per month in late fees.

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I have read and agree to the terms of the Financial Policy given to me by Westside Podiatry Center.

PATIENT SIGNATURE: _____ DATE: / /

PRINT PATIENT NAME: _____