Welcome To Westside Podiatry Center

Patient Information:

Name____**Date**____________________________

Address ___________________________ **City/State** ________________________ **Zip** ______________

Home # ____________________________ **Work #** _________________ **Cell #** ____________________

E-mail ____

Social Security # ____________________ **Date of Birth** _______________________ **Age**____________

Gender M F Marital Status S M D W Spouse ____

Your 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:

Name: ____ **Phone #** ___________________________

Whom May We Thank For Referring You? ____

I authorize Dr. Farrell, Dr. Rounds, Dr. Smith, Dr. Wadie, Dr. Stanley, Dr. Beabes, and Dr. Bersani 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. Smith, Dr. Wadie, Dr. Stanley, Dr. Beabes, and Dr. Bersani of the benefits otherwise payable to me. Also, I hereby give permission to Dr. Farrell, Dr. Rounds, Dr. Smith, Dr. Wadie, Dr. Stanley, Dr. Beabes, Dr. Bersani 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** ___________________________

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.

Name: ______________________________________Date of Birth: ___/___/____ Appointment Date:_______

Height: ____________ Weight: ___________ Have you had a Flu shot from 8/1/23-3/31/24? Yes No

Reason for Visit: ____

____

Date of Onset: ______________________________

Primary Medical Doctor: __________________________________ Date Last Seen: _____________________

Doctor Treating for Diabetes: ______________________________ Date Last Seen: _____________________

Former Podiatrist: _______________________________________ Date Last Seen: _____________________

MEDICAL HISTORY (Circle only those items that apply): NONE

Diabetes – Diet / Oral / Insulin _____ # Years
Kidney Disease
Anemia
Peripheral Vascular Disease
Arthritis: Rheumatoid / Osteoarthritis / Lupus
Liver Disease / Hepatitis / Jaundice
High Blood Pressure
GI Ulcers / Stomach Problems
Blood Disease / Bleeding Disorders
Artificial Heart Valves / Artificial Joints
Heart Disease / Angina / Chest Pain
Varicose Veins
Epilepsy
Hypothyroidism / Thyroid Problems
Autoimmune Disease / HIV / AIDS
Rheumatic Fever
Asthma / Emphysema / Lung Problems
Eye Pathology
Charcot Joint
If Over 65 – History of Falls: Yes No
Gastric Reflux / Hiatal Hernia
Skin Problems / Psoriasis
Gout
Fibromyalgia
Fainting / Seizures
Neuropathy
Anxiety
Depression
Broken Bones in Feet / Legs
Cancer (Type)__________________
Chemical Dependency
Weight Loss / Gain (Unexplained)
Back Problems / Herniated Discs
Stenosis
Circulatory Problems
Chronic Diarrhea
MS
CVA (Stroke) / TIAs
High Cholesterol
Leg Cramps / Numbness
Other Medical Problems (Please List):____

____

SURGICAL HISTORY (Circle only those items that apply): NONE

Foot Surgery: Type___________________________Date: _____ / ____ / _____ Right Left (Please Circle)

Angioplasty
Knee Replacement
C-Section
Cataract
Carotid Artery
Gall Bladder
Breast Biopsy / Lumpectomy
Arterial Bypass
Venous Ligation
Open Heart
Back Surgery
Hernia Repair
Hip Replacement
Appendectomy
Mastectomy
Kidney Stones
Kidney Removal
Pacemaker
Tonsillectomy
Prostate
Heart Bypass
D & C
Hysterectomy
Other Surgical History (Please list): ____

____

Name: ___________________________________Date of Birth: ___/___/____ Appointment Date:_______

Medications (Please list both Prescription & Non-Prescription Medications/Supplements): NONE

____

____

____

Pharmacy: ____________________________________ Phone: ________________ Fax: _______________

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

Personal or Family History of Blood Clots? Yes / No Details:_____________________________

SOCIAL HISTORY (Circle only those items that apply): NONE

Alcohol ____________ Tobacco___________ # of Packs Per Day
Caffeine (Coffee / Tea / Soda)_________________ # Cups / Cans / Bottles Per Day
Recreational Drugs
Activities (Sports/Exercise)____

____

ALLERGIES (Circle only those items that apply): ☐ **No Known Drug Allergies**

Novocain	Adhesive Tape	Motrin / Advil
Aspirin	Latex	Cortisone
Codeine	Iodine	Sulfa
Penicillin	Neosporin	Other: _________________________________

****

FOR OFFICE USE ONLY

BP ____________ Pulse __________ Respirations ________ O_2 _______ Shoe Size _________

REVIEW OF SYSTEMS

HE	Dizziness / Fainting / Headaches / Double Vision / Infection
ENT	Difficulty Swallowing / Hoarseness / Hearing Loss / Infection / Ringing In Ear / Nosebleed / Earaches / Sores
Respiratory	Asthma / Bronchitis / Difficulty Breathing / Shortness of Breath / Vomiting Blood / Emphysema
Cardiovascular	Hypertension / Murmurs / Chest Pain / Edema / Claudication / Ulceration / Phlebitis
Gastrointestinal	Jaundice / Cirrhosis / Hepatitis / Abnormal Stool
Musculoskeletal	Joint Pain / Joint Swelling / Muscle Pain / Poststatic Dyskinesia / Weakness / Back Pain
Neurologic	Paralysis / Stroke / Tics / Tremors / Seizures / Numbness
Dermatology	Rash / Hypertrophic Nails
Mental Status	Alert and Oriented / Alert, Not Oriented / Confused / Lethargic

Tech: ____

WESTSIDE PODIATRY CENTER, LLP

JAMES W. FARRELL, D.P.M. **CHAD R. ROUNDS, D.P.M.**
DANIEL T. SMITH, D.P.M. **EDWARD L. WADIE, D.P.M.**
KAREN A. STANLEY, D.P.M. **JUSTIN C. BEABES, D.P.M.** **ADAM T. BERSANI, D.P.M**

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 315-546-0290. The billing office is open Monday 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 Advance 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. 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.

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.

5104 W. Genesee Street, Camillus, NY 13031, (315) 701-3348
27 Fennell Street, Skaneateles, NY 13152, (315) 685-3338
7458 Oswego Road, Liverpool. NY 13090-1500, (315) 546-0285
130 East 2nd Street, Oswego, NY 13126, (315) 532-6600
6253 State Rte. 31, Cicero, NY 13039, (315) 516-8193

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 546-0290 immediately for assistance in managing your account.

- **If you have a High Deductible Health Plan*, established patients will be requested to pay $50, new patients $100 toward services at the time of your visit.** *We will continue to bill your insurance for the full amount of your visit to ensure all charges will count toward your deductible. In the unlikely event of an overpayment, we will promptly refund any monies due to you.* If you want to schedule surgery, a percentage of the deductible will be due **before** the surgery is scheduled.

  **Does not apply to Medicare, Medicaid, Workers Compensation, or Post-op visits after surgery.)*

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 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 a fee of $30 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.

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: ____

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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: ______________________

This form expires one year from the date of signature.

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