



1711 Congress St.
Portland, Maine 04102
207 773 5800

ATLANTIC FOOT & ANKLE CENTER

Dear Patient:

Welcome to Atlantic Foot & Ankle Center.
The following is paperwork that will need to be filled out prior to your appointment.
The paperwork includes two pages of insurance information and medical history, our financial policy and our confidentiality policy.

To schedule an appointment or questions regarding your appointment, please call Darcy, Patient Care Coordinator.

If you have questions regarding billing, please call Kellie, Patient Billing Coordinator.

You may also call my nurse, Nancy, with medical questions.

Please arrive for your appointment 15 minutes early to complete your paperwork, if you haven't already done so. Also, please remember to bring your insurance cards with you.

We look forward to your appointment with us.

Thank you.

Sincerely,

Dr. John B. Perry, DPM-FACFAS



WELCOME

Appt Date: ___/___/___

PATIENT INFORMATION:

Patient _____

Social Security _____

Address _____

Sex M F Birth Date _____

City State Zip

Marital Status: Single Married Widowed Divorced

PHONE NUMBERS:

Home Phone _____ Work Phone _____

In case of emergency, contact: _____ Phone # _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION:

Primary Insurance Company _____ Referral Y N

Responsible Party Name _____

Responsible Party Social Security # _____ Birth Date _____

Secondary Insurance Company _____ Policy # _____ Group _____

Employer _____ Address _____ Ph # _____

ASSIGNMENT & RELEASE:

I, the undersigned certify that I (or the dependant) have insurance coverage with _____ and assign directly to Dr. John B. Perry, DPM all insurance benefits, if any, otherwise payable to me for services rendered and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release information necessary to secure the payment benefits authorize the use of this signature on all insurance submissions.

X

Responsible Party Signature

PODIATRIC HISTORY:

What is the chief complaint for which you came to be treated? (Include feet, ankles, knees, thigh & hip complaints) BE SPECIFIC: _____

When did the problem start? _____

Have you ever been to a podiatrist before? Y N If yes, please list: _____

Please indicate which foot problems you have or had in the past:

Ankle Pain	YES	NO	Corns or Calluses	YES	NO	Swelling in Ankles or		
Athlete's Foot	YES	NO	Plantar Warts	YES	NO	Feet	YES	NO
Bunions	YES	NO	Tired Feet	YES	NO	Flat Feet	YES	NO

MEDICAL HISTORY:

Circle "YES" or "NO" to indicate if you have had any of the following:

AIDS/HIV	YES	NO	Fainting	YES	NO	Shortness		
Anemia	YES	NO	Foot or			of Breath	YES	NO
Angina	YES	NO	Leg Cramps	YES	NO	Special Diet	YES	NO
Arthritis	YES	NO	Gout	YES	NO	Stroke	YES	NO
Asthma	YES	NO	Headaches	YES	NO	Ulcers	YES	NO
Back			Heart			Varicose		
Problems	YES	NO	Disease	YES	NO	Veins	YES	NO
Bleeding			Hemophilia	YES	NO	Weight Loss		
Disorders	YES	NO	Hepatitis	YES	NO	(Unexplained)	YES	NO
Cancer	YES	NO	Jaundice	YES	NO	Chemical		
Chest Pain	YES	NO	High Blood			Dependancy	YES	NO
Circulatory			Pressure	YES	NO	Kidney		
Problems	YES	NO	Liver			Problems	YES	NO
Diabetes	YES	NO	Disease	YES	NO	Epilepsy	YES	NO
						Phlebitis	YES	NO

Major surgeries you have had: _____

Family Physician: _____ Phone Number: _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years?

If yes, please explain: _____

MEDICATIONS:

Include prescriptions, over-the-counter medications and vitamins:

ALLERGIES:

Circle "YES" or "NO" if you are allergic to any of the following:

Adhesive/Tape	YES	NO	Demerol	YES	NO	Other: _____
Aspirin	YES	NO	Iodine	YES	NO	_____
Local Anesthetic	YES	NO	Penicillin	YES	NO	
Codeine	YES	NO	Sulfa	YES	NO	

SHOE SIZE _____ HEIGHT _____ WEIGHT _____

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form, I should ask the doctor or a member of the staff for assistance. I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed in the diagnosis and / or treatment of my feet.

Patient's Signature X _____ Date: _____

FINANCIAL POLICY

ATLANTIC FOOT & ANKLE CENTER

John B. Perry, DPM

1711 Congress St. Portland, ME 04102
Tel (207) 773-5800 Fax (207) 773-0277

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

In order to assist you in making payment for your Podiatric treatment, the following options are listed. Please read them carefully and feel free to discuss them with us.

**All patients must fill out our Information and Insurance form completely before seeing the doctor.
If you DO NOT have insurance, payment is due in full at the time treatment is provided.
You may make payment using cash, check, MasterCard, Visa or Discover.**

Regarding Commercial Insurance

If you have commercial insurance, we will submit your claim to your insurance carrier for you. You are responsible for any co-payments due at the time of your visit. This amount is determined by your insurance carrier and is located on your insurance card. Once our office has received payment from the insurance company, you will be billed for any amount still owed. You will be required to pay the balance in 30 days. After 30 days, the account will accrue monthly interest. Outstanding balances over 120 days old will be forwarded to a collection agency, unless prior payment arrangements were made. If your account is forwarded to collection, you will be responsible for the balance due, as well as collection and attorneys fees. If there is a payment credit, a check will be issued to you within 30 days. A \$27.00 fee will be assessed for checks returned due to non-sufficient funds.

Referrals

For HMO, POS and other insurance plans that require referrals, **it is your responsibility to obtain this from your Primary Care Physician prior to your visit.** If the referral is not received by your appointment date, you will be required to sign a referral waiver. In the event you do not receive a referral from your PCP, you will be entirely responsible for the cost of the treatment.

Medicare Insurance

This office accepts Medicare assignment. However, Medicare patients are fully responsible for the initial yearly \$100.00 deductible and the 20% co-insurance. Federal law requires that physicians collect this amount. After Medicare has processed your claim, charges will be billed to your secondary insurance company. In the event you do not have any additional insurance coverage, you will receive a bill for the Medicare deductible and/or coinsurance.

Supplies

Payment is required for all supply items \$50.00 or less at time of service. We will provide the patient with the necessary information to allow them to bill the supplies to their insurance company if they desire. **All supply item sales are final.**

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. The percentage of coverage by your insurance company may be based on your insurance company's own reduced fee schedule for medical services and may be less than actual charges resulting in lower coverage for you. We have no control over this situation. Lower payment is a direct result of the plan selected by your provider.

Missed Appointments

**Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments a \$34.00 fee.
Please help us serve you better by keeping scheduled appointments. Three (3) missed appointments may result in discharge of care.**

Thank you for taking the time to carefully read our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

X _____
Signature of Patient or Responsible Party

Date _____

X _____
Signature of Co-responsible Party

Date _____

ATLANTIC FOOT & ANKLE CENTER

John B. Perry, DPM

1711 Congress St. South Portland, ME 04102

Tel (207) 773-5800 Fax (207) 773-0277

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.
THIS PRIVACY OF YOU HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This Notice takes effect on 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy policies, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Required by Law: We may use or disclose your health information when we are required to do so by law.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certifications, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to reject to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a d determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim or abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. If you request copies, we will charge you \$10.00 for the first page and \$0.25 for each additional page for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or locations, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with your by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

PATIENT'S SIGNATURE

DATE