DELAWARE
TOTAL FOOT AND ANKLE
CENTER

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Unit 1
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Welcome to Delaware Total Foot and Ankle Center

Patient Information

Patient Name:_________________________________**DOB:**________**SSN:**____________________
Home Address:____**Apartment:**__________
City:__________________________________**State:**__________**Zip Code:** ____________________
Home Phone:____________________________________**Cell Phone**: ________________________
Email Address: ____

Would you like access to your records online through our secure patient portal? ☐ Yes ☐ No

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Preferred Language: ____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unreported/Refused to Report

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ More than one race ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Unreported/Refused to Report

Primary Physician:____Phone:_________________
Specialty Doctors:____
Pharmacy:____Phone:__________________
Emergency Contact:______________________________________Emergency Phone:_________________

Disclosure to Designated Family/Friends Caregivers

I allow Delaware Total Foot and Ankle Center to disclose medical information as needed to the following designed individual(s) involved with my health care. I understand that I am not required to list anyone. I also understand that I may change my list in writing at any time.
Print Name:_______________________Relationship:_______________Phone #: _________________
Print Name:_______________________Relationship:_______________Phone #: _________________

Insurance Information

Insurance:________________________________Group #:________________ID #:______________________

Person Responsible for Account:____

Relationship to Patient:__________________________D.O.B:_______________SSN:____________________

Address (if different from patient):____

Secondary Insurance:_____________________Group #:__________________ID #: ____________________

Person Responsible for Account:____

Relationship to Patient:__________________________D.O.B:_______________SSN:____________________

Is this a compensation or work relate case? ☐ Yes ☐ No Date of Injury: _____________

New Patient Review of Symptoms

Name:____D.O.B:________________________

Shoe Size:___________________Height:__________________________Weight:______________________

- Have your ever been to a podiatrist before? ☐ Yes ☐ No
- Last Visit? ____
- What is your chief complaint you are here to address today?

____

____

- Description of Pain (dull, sharp, aching, etc.):____
- Aggravating Factors (when is the pain at its worst?):_____________________________________
- How long has this bothered you?________Days________Weeks______Months______Years
- Relieving Factors: ☐ Rest ☐ Ice ☐ Heat ☐ Medications ☐ Home Remedies ☐ Stretching

  ☐ Other:____

- Does your foot pain limit your activities? ☐ Yes ☐ No
- Do you have difficultly/pain walking? ☐ Yes ☐ No
- Have you had any previous treatment for this problem? ☐ Yes ☐ No

If yes, please explain: ____

____

- Have you had diagnostic imaging for this problem? ☐ Yes ☐ No

If yes, when and where were they done? ____

____

- Please indicate which foot problems you **now have or have had** in the past: ________________________
____

	Ankle instability		Ingrown toenail		Numbness feet/toes
	Ankle pain		Athlete's Foot		Hammertoes
	Ankle stiffness		Corns/Callous		Burning in feet/toes
	Ankle swelling		Plantar wart		Pain in big toe
	Achilles tendon pain		Heel or arch pain		Toenail problem
	Pale or blue feet		Cramps in feet or legs		Fungus in toenails
	Swelling in feet/ankles		Leg pain		Dry skin
	Pain/fatigue of feet		Bunions		Itchy feet
	Poor healing sore/ulcer		Flat feet		Other:

Medical History

Name: ____

	Abdominal Aortic Aneurysm		COPD		High Cholesterol		Rash
	AIDS/HIV		CVA (Stroke)		Hypertension		Rheumatic Arthritis
	Allergies		Depression		Keloids/Scars		Rheumatic Fever
	Angina		Diabetes		Kidney Disease		Sciatica
	Anxiety		Diverticulitis		Liver Disease		Sinus Problems
	Arthritis		Edema		Low Blood Pressure		Skin Disorder
	Artificial Heart Valve		Epilepsy		Lyme's Disease		Sleep Apnea
	Asthma		Fainting		Macular Degeneration		Stomach Ulcers
	Atrial Fibrillation		Fracture		Mitral Valve Prolapse		Thyroid Disease
	Back Problems		GERD		Neuropathy		Tuberculosis
	Benign Prostatic Hypertrophy		Glaucoma		Osteopenia		Vascular Disease (PVD)
	Blood Disorder		Gout		Osteoporosis		Varicose Veins
	Blood Clots/DVT/PE		Headache		Palpitations		Venereal Disease
	Cancer		Hearing/Ear Problems		Phlebitis		Weight Loss
	Cardiomyopathy		Heart Diseases		Pneumonia		Other:
	Circulation Problems		Heart Murmur		Polio		Other:
	Congestive Heart Failure		Hepatitis		Psychiatric Care		Other:

List other Medical History: ____

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____

____

Surgery

	Amputation of foot/toes		Hip replacement
	Ankle surgery		Knee replacement
	Bariatric surgery		Open heart surgery
	Bunion surgery		Organ transplant
	Colon surgery		Pacemaker/Defibrillator
	Foot surgery		Stents in leg
	Fracture repair		Stents in heart
	Hammertoe		Vein surgery

Please list all other surgeries: ____

____

____

Allergies

	No Known Drug Allergies		Betadine		Iodine		Lidocaine		Tylenol
	Aspirin		Codeine		Latex		Sulfa		Vicodin

Please list all other allergies: ____

____

____

____

Medication List

Please list current medications prescribed by a doctor, including over the counter medications, vitamins, and supplements: *You may provide a list of medications as well.*

____

____

____

____

Social History

Name:____D.O.B.________________

Please indicate with an (**X**) any of the responses that pertain to you

- **Alcohol:** ☐ None ☐ Rarely ☐ Moderate ☐ Quit How much?________________
- **Drug Use:** ☐ None ☐ Rarely ☐ Moderate ☐ Quit How much?________________
- **Tobacco Use**:
  - **Cigarettes:**
    - ▫Current Smoker ____ Packs per day _____ Number of years
    - ▫Former Smoker ____ Number of years _____ Quit date
  - **Other Tobacco:**
    - ☐ Vape ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
  - **Exercise:**

Do you exercise daily regularly: ☐ Yes, list activities:____

☐No

Family History

Please indicate with a (**X**) for any responses below that pertain to your family members

Medical Condition	Father	Mother	Sibling	Children
Living				
Deceased				
AAA- Abdominal Aortic Aneurysm				
Cancer				
COPD				
Diabetes				
DVT				
Gout				
Heart Disease				
Hypertension				
Thyroid				
Unknown				

Authorization to Access Electronic Prescription Records

I authorize Delaware Total Foot and Ankle Center, Dr. Joseph Wendolowski to view my external prescription history via electronic prescribing services. I understand that prescription his- tory from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff here. It may include prescriptions back in time for several years and may include prescriptions to treat HIV, sub- stance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Delaware Total Foot and Ankle Center medical record.

________I agree to allow access to my electronic prescription records.

Health Information Exchange (HIE)

Delaware Total Foot and Ankle Center also participates in electronic health information ex- changes (HIEs) with hospitals and various other health care providers. I authorize Delaware Total Foot and Ankle Center and the HIEs with which it participates to share my health in- formation, through the HIE networks, for purposes permitted by law, including my treatment and coordination of my care, with all health care providers that are authorized under the HIEs' policies and applicable law to access my information. I understand and agree that the information about me that may be shared and accessed through the HIEs may include information about HIV/AIDS status, sexually transmitted diseases, family planning, mental health treatment, genetic test results, use of alcohol and other substances and other sensitive categories of my health information. I understand that I have the right to "opt-out" of having my information shared through HIEs.

________I agree to allow access to HIE (Health Information Exchange).

Consent to Treat

I, the underlying, voluntarily consent to and authorize Dr. Joseph Wendolowski and the employees of Delaware Total Foot and Ankle Center to provide such podiatric care and examinations, on a continuing basis, and to administer such routine diagnostic, radiological and/or therapeutic procedures, test and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgement of Dr. Joseph Wendolowski, including, but not limited to, collecting and testing specimens, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

________I agree to treatment as described above.

Acknowledge and Agreement

Please initial the following stating you have read and agreed.

________I acknowledge receipt of the Notice of Privacy Practices (HIPAA Privacy Rules).

________I have read this form, my questions have been answered, and I understand and agree to its content.

Print Patient/Representative's Name:______________________________**D.O.B:**__________

Patient/Representative's Signature:______________________________**Date:** __________

If signed by Authorized Representative, print name of Signatory Patient:___________________________
Relationship to Patient/Authority to Sign for: ____

FINANCIAL POLICY FOR DELAWARE TOTAL FOOT AND ANKLE CENTER, LLC

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan, we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for **paying their annual deductible** if it has not yet been met. You are also responsible for any copayments, which are usually **20% for the allowed amount** for an item or service

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and /or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES: all copayments and deductibles must be paid at the time of services. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments or deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services that you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent a statement for any outstanding balance owed after payment and/ or explanation of benefits (EOB) is received from your insurance company/companies. **If a second or third statement is required, a $10 rebilling fee will be added to your account for each subsequent statement. You will be sent up to three notices of your financial responsibility** (coinsurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/ companies. **If payment is not received after the third and last notice, you account will be forwarded to**
collections or small claims court, where additional fees will apply. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or Visa/MasterCard/AMEX. An additional $50.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it our office to be applied to your balance.

Medical Record Fees: The fees that a practice may charge Delaware patients for copies of the patient's medical records are limited by a rule that was effective November 11, 2009. The fee limits apply regardless of whether the practice provides the copies directly to the patient or to another physician. The limits also apply to both electronic and paper copies.

- $2.00 per page for pages 1-10
- $1.00 per page for pages 11-20
- $0.90 per page for pages 21-60
- $0.50 per page for pages 61 and above

In addition to the fees above, practices may charge the following:

- When the records are mailed, we will charge the actual cost of postage or shipping.
- When the type of record requested cannot be photocopied (such as copies of radiology films), we will charge $10 dollars for a CD of all films.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Delaware Total Foot and Ankle Center, LLC** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, copayments and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or re- quested by physicians to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms. **I have read the above policy regarding my financial responsibility to Delaware Total Foot and Ankle Center, LLC for medical services provided. I agree to pay Delaware Total Foot and Ankle Center, LLC any balance unpaid by my insurance carrier for myself or the below named person.**

Missed Appointments

I understand that if I miss an appointment or cancel an appointment within **24 hours** I will be charged **$35.00.**

Patient Name (print):____________________________________Signature:_______________________________________

FINANCIALLY RESPONSIBLE PARTY

Name (print):____Signature:____