Brookwood Foot Care

John P. Calcatera, DPM, PC

SSN:______________________ **Sex**: M F **Age**:____________ **Shoe Size**: ________

Name: ____
First Last

Address: ____
Street

____
City State Zip

Date of Birth:________/_______/________

Phone: **Home**: ___________________________

Work: ___________________________

Cell:____________________________ **Cell Company**: ___________________

Do you want text message appointment reminders? Y N

Email:____

Do you want email appointment reminders? Y N

Marital Status: S M D W

Race:
- ☐ Asian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Hispanic
- ☐ Japanese
- ☐ Native American
- ☐ Native Hawaiian
- ☐ Other
- ☐ White
- ☐ Decline to Answer

Language:
- ☐ English
- ☐ Chinese
- ☐ French
- ☐ Italian
- ☐ Spanish
- ☐ Vietnamese
- ☐ Decline to Answer

Ethnicity:
- ☐ Caucasian
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Decline to answer

Insurance Information

Policy Holder: ____
Name

Date of Birth:_______________ **Relationship to Patient:** ______________________

Patient Occupation:____

Employed by:____ **Employer Phone:** ______________________________

Name of (spouse)(parent)(other):____ **Phone**: _____________________________

Occupation:____ **Employed by:** ____

In case of emergency, notify: _____________________________________ ______________________ ___________________
Name Relationship to Patient Phone

Primary Care Doctor:____ **Last Visit**: ____________________________

Previous Podiatrist:____ **Last Visit**: ______________________________

Whom may we thank for referring you to our office? ____

I state that the information is true to the best of my knowledge and I hereby give my permission to John P. Calcatera, D.P.M., P.C. to administer treatment and perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition. I will be responsible for all charges incurred by me. Should collection proceedings become necessary, I agree to pay all costs of collection including a reasonable attorney's fee and waive all rights to claim personal property exempt under the laws of the State of Alabama.

SIGNATURE:____ **Date**: ________________________

Brookwood Foot Care

Date: ______________ **Name**: ____ **Weight**:________ **Height:** _________

What is your chief foot complaint?____

____

____

How long have you had it? _______________________ **Has your problem been getting worse?** ______________________________________

What have you done for your problem? ____

Allergies: ☐ NO KNOWN ALLERGIES

☐ Aspirin ☐ Demerol ☐Latex ☐ Neosporin ☐ Penicillin ☐ Tape ☐ Other ___________________________

☐ Codeine ☐ Iodine ☐ Morphine ☐ NSAIDs ☐ Sulfur/Sulfa ☐ Novo-/Carbo-/Xylo- caine

Current Medications AND Dosage (mg): (include birth control, supplements, prescription, and non-prescription drugs)

____

____

____

Do you have a history of any of the following?: (check all that apply) ☐ NONE

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bleeding disorder
☐ Blood clot
☐ Cancer
☐ Chest pain
☐ COPD
☐ Depression
☐ Diabetes (Type 1)
☐ Diabetes (Type 2)
☐ Epilepsy
☐ Fibromyalgia
☐ Gastric reflux
☐ Gout
☐ Heart attack
☐ Heart disease

☐ Hepatitis C
☐ High blood pressure
☐ High cholesterol
☐ HIV
☐ Kidney disease
☐ Liver disease
☐ Low back pain
☐ Mitral valve prolapse
☐ Nervousness
☐ Neuropathy
☐ Osteoporosis
☐ Pneumonia
☐ Recent weight loss
☐ Recent weight gain
☐ Rheumatoid arthritis
☐ Sexually transmitted disease

☐ Shortness of breath
☐ Skin condition
☐ Sleep apnea
☐ Stomach ulcers
☐ Stroke
☐ Swelling of legs
☐ Thyroid condition
☐ Tuberculosis
☐ Tumors
☐ Urinary tract infections
☐ Other: ____________________

____

____

Alcohol use? Y N

#/day ________ **How long?** __________

Tobacco use? Y N

 # packs/day______ **How long?** ___________

Females: Are you pregnant? Y N

Are you nursing? Y N

If > 64 years old:

Have you had any falls in the past year? Y N

If Y, # of falls? _________

Were you injured? Y N

DIABETIC PATIENTS →

Most Recent Hemoglobin A1C = _______
Date Measured = _______________

Surgical History & Approximate Dates: ☐ NONE

☐ Appendix ☐ C-section ☐ Heart bypass ☐ Hip replacement ☐ Shoulder ☐ Other:

☐ Back ☐ Foot ☐ Heart stent ☐ Hysterectomy ☐ Tonsillectomy _____________________

☐ Bladder tack ☐ Gall bladder ☐ Hemorrhoid ☐ Knee replacement ☐ Tubal ligation

☐ Cataracts ☐ Gastric bypass ☐ Hernia ☐ Neck _____________________

Any complications with prior surgery or anesthesia? Y N **Have you been hospitalized for any other reason(s)?** Y N

Family History: ☐ NONE

☐ Arthritis ☐ Blood clot ☐ Diabetes ☐ Gout ☐ High blood pressure ☐ Psoriasis

☐ Bleeding disorder ☐ Cancer ☐ Foot deformity ☐ Heart disease ☐ Kidney disease ☐ Stroke

Preferred Pharmacy: __________________________ ________________________ _________________________ ____________________

Name City Street Phone

☐ Y ☐ N - **I consent to allow Brookwood Foot Care to retrieve my prescription history from my pharmacy.**

SIGNATURE: ____ **Date**: ___________________________

FINANCIAL POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medial 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 do participate with but do not have a current 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 applicable) will be billed for you. However that does not mean all services are covered. Patients are responsible for paying their annual deductible if it has not been met. You are also responsible for any co-payments which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance after payment and/or explanation of benefits (EOB) is received from your primary insurance company (if applicable, except for Medicaid because Medicaid does not pay for podiatry in the state of AL).

CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLES: All co-payments, co-insurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

SELF-PAY ACCOUNTS: 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 you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payments of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates 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 services received, unless your referral is presented at the time of the visit.

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: After payment and/or EOBs are received from your insurance company there is a co-insurance or deductible that we are not aware of at the time of service. You will be sent three (3) notices of your financial responsibility. After the third and final notice, your account may be forwarded to collections. All cost incurred, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due at the office. 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, Visa, MasterCard, American Express, Discover.

An additional $35 fee will be added to your statement if your check is returned for insufficient funds.

There is a $25 fee for any forms completed by our office on your behalf.

I have read the above policy regarding my financial responsibility to John P. Calcatera, DPM, P.C. for medical services provided. I agree to pay John P. Calcatera, DPM, P.C. any balance unpaid by my insurance carrier for myself or the below named person.

ASSIGNMENT OF BENEFITS: I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to John P. Calcatera, DPM, P.C. all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurances, and/or non-covered services. I hereby authorize the doctor to release all information necessary for payment of benefits. I authorize release of medical information to my insurance carrier or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

Patient signature:______________________________________Date:_____________________

FINANCIALLY RESPONSIBLE PARTY:

Signature :____Date:_____________________

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) Date

____
Parent or Authorized Representative (if applicable)

____
Signature

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.