Jewett Podiatry Center, 7 Federal Street, Suite 33, Danvers, Ma

IN ACCORDANCE WITH THE AFFORDABLE CARE ACT, PLEASE FILL OUT ALL PAGES COMPLETELY AND RETURN TO OUR OFFICE PRIOR TO YOUR UPCOMING APPOINTMENT ON_____

YOUR INSURANCE CARDS AND PHOTO ID ARE REQUIRED FOR EACH APPOINTMENT.

NAME: *FIRST*_____*MIDDLE INITIAL*_____*LAST*_____

*Address:*_____*City*_____*ZipCode*_____

Home Phone _____*Cell* _____***DATE OF BIRTH***:_____

*Patient EMAIL ADDRESS*_____*Referred by:*_____

RACE_____***LANGUAGE***_____***ETHNICITY*** (circle one) *HISPANC / NOT HISPANIC*

PRIMARY CARE PHYSICIAN_____***DATE LAST SEEN***_____

INSURANCE, Primary_____ *Policy ID#* _____ *Group #*_____

*Subscriber Name*_____*Relationship*_____*DOB*_____

INSURANCE, Secondary_____ *Policy ID#* _____ *Group#*_____

*Subscriber Name*_____*Relationship*_____*DOB*_____

EMERGENCY CONTACT: *Name*_____

*Relationship*_____*Phone#*_____

PHARMACY NAME:_____*Telephone#*_____

*Pharmacy street address*_____*City*_____

ASSIGNMENT OF BENEFITS: (ALLOWS US TO FILE FOR YOUR INSURANCE) I hereby assign all medical, to include major medical benefits to which I am entitled including Medicare and private insurance and any other health plans to Jewett Podiatry Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. I authorize Jewett Podiatry Center to download my medication history and Rx benefits into my account from a Rx clearinghouse.

Signed:_____Date_____ **1**

NAME_____**DATE OF BIRTH**_____

VITALS: WEIGHT_____HEIGHT_____SHOE SIZE_____*MED, WIDE, X-WIDE, XX-WIDE*

CHIEF COMPLAINT ***REASON FOR TODAY'S VISIT / HISTORY OF PRESENT ILLNESS***

What is the reason for your visit today? _____

Where is the problem and/or pain located?_____

Describe how it feels? Burning, throbbing, sharp, dull, aching, numb, other? _____

_____

Have you seen another Doctor? Who?_____When?_____

MEDICATIONS *Please list or attach your current medications and dosages, including any vitamins or supplements:*

_____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY: ***Please circle all that apply below.***

Asthma
ADHD
Aneurysm
Back ***specify***_____
Blood clots
Bleeding Tendencies
Blood *disease* ***specify***_____
Bone Infection
Cancer ***specify***_____
Colitis
Diabetes
Emphysema
Eye Conditions ***specify***_____
Eczema
Fracture ***specify***_____
Gout
GERD
Gallbladder Disease
G.I. Ulcer ***specify***_____
High Blood Pressure
HIV/AIDS
High Cholesterol
Hypothyroidism
Heart Disease
Heart Attack
Hepatitis
IBS
Kidney Dialysis
Kidney Disease ***specify***_____
Lung Problems ***specify***_____
MRSA
Neurological Disease ***specify***_____
Osteoarthritis
Parathyroid
Psoriasis
Peripheral Vascular Disease
Peripheral Neuropathy
Pain Syndrome ***specify***_____
Prostate Condition ***specify***_____
Psychiatric Disease ***specify***_____
Rheumatoid Arthritis
Stroke
Skin Ulcers
Skin Cancer ***specify***_____
Tuberculosis
Vein Disease
Other_____
_____
_____

Name_____DATE OF BIRTH_____

IMMUNIZATIONS:

Date of last flu shot_____Date of last pneumonia shot_____

ALLERGIES: Are you allergic/sensitive? How does it affect you? ***Please circle and explain.*** NO KNOWN ALLERGIES

ADHESIVE TAPE ANESTHETICS ASPRIN BARBITURATES IODINE LATEX METAL NOVOCAIN

PENICILLIN SEDATIVES SEAFOOD SULFA DRUGS OTHER: _____

SOCIAL HISTORY: Do you exercise? Yes / No Frequency: _____Type: _____

Do you smoke? Current every day smoker Current some days smoker Former smoker Never smoked

Do you drink alcohol? Yes / No / Quit this year _____

Have you ever used cocaine or other illegal drugs? Yes / No

_____

PAST SURGICAL HISTORY: ***Please list any past surgeries and year.*** _____

_____

_____

_____

_____

_____

FAMILY HISTORY: ***Please indicate any major illnesses of your parents, siblings or children.***

_____

_____

_____

_____

_____

Jewett Podiatry Center

FINANCIAL POLICY

Thank you for choosing Jewett Podiatry Center as your health care provider. ***We are committed to your treatment being successful.*** The following is a statement of our Financial Policy that we ask you to *read, agree to and sign prior to any treatment.*

1. Payments are due at time of service, including copayments, deductibles, co-insurance and any previous balance owed.

2. Patient is responsible for insurance referrals from their Primary Care Physician. We recommend you contact your insurance carrier whenever our office refers you to any outside diagnostic testing (x-rays, lab work, surgery etc) to verify coverage and to ensure that you do not require a pre-authorization.

3. *Written or verbal authorizations from insurance plans or management groups are not a guarantee of payment.* All claims are reviewed by the insurance carriers *AFTER* services are rendered and authorizations can be denied at the time of review. Denied claims become the patient's responsibility.

4. Statements are mailed after the insurance company has paid their portion. The account is then *payable within 15 days of receipt of statement*. Overdue accounts are subject to a $15 fee.

5. Additional fees:
   a. Returned checks--$45 (plus original fee)
   b. Copies of medical records--$15-$25 (patient portal is free of charge)
   c. Cancellation fee (for apts canceled less than 24 hour notice)
      Established patient--$30
      New patient--$50

I HAVE READ THE ABOVE AGREEMENT AND AGREE TO THE TERMS AND CONDITIONS.

_____ _____

Patient or Patient's Representative Signature Date

Jewett Podiatry Center

Your Rights Regarding Your Health Information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care, (such as family members and friends) except when required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to *Jewett Podiatry*.
4. You have the right to a copy of this notice. You are entitled to receive a copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front office receptionist.
5. You have the right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, *Jewett Podiatry*, all complaints must be submitted in writing. You will not be penalized for filing a complaint.
6. Any photos taken from me at *Jewett Podiatry* will solely be used for purposes of electronic medical chart keeping and will not be shared with any marketing and/or advertising agency, unless requested by any federal or state governmental agency.

If you have any questions regarding this notice or our health information privacy policies, please contact *Jewett Podiatry*.

I hereby acknowledge that I have been presented with a copy of *Jewett Podiatry's* Notice of Privacy Practices.

SIGNATURE: _____ DATE: _____

PRINT NAME OF PATIENT: _____

(Sept 2019)