POTOMAC PODIATRY GROUP, PLLC

Shruti A. Patel, DPM, MS, DABPM, AACFAS
Peter N. Brieloff, DPM, FACPM, FACFAS
Lyle T. Modlin, DPM, FACFAS
Alesia L. Madden, DPM
Vincent J. Bonini, DPM, FACFAS
Robert J. Toomey III, DPM, FACPM, FACFAS
Brittany E. Mayer, DPM, DABPM, AACFAS
Mark D. Dollard, DPM, DABPS, FACFAS
Tobias J. Glister, DPM, FACFAS
Jared C. Melman, DPM, AACFAS

PATIENT REGISTRATION

Welcome to our office! So that we may serve you to the best of our ability, please complete this form as accurately as possible and return it to the receptionist.

Last Name *_____First Name *_____MI_____

Address *_____

City *_____State *_____Zip Code *_____

Birthday *_____Age *_____"Nick Name"_____

Home Phone *( )_____Cell Phone( )_____

Work Phone( )_____Ext_____Email Address *_____

(This email is never shared and is used to give you access to your medical record and statements)

Marital Status * Single / Married / Separated / Divorced / Widowed Gender * Male / Female

Emergency Contact *_____Relationship *_____

Contact Phone( )_____

Medical Doctor *_____Phone( )_____

Address_____

Date Last Seen *_____

Referred by *_____(example: Doctor/Patient/Insurance/Phone book/Online/Sign)

Primary Insurance Company *_____ID # *_____

Group Number *_____Name of Policy Holder *_____

Date of Birth of Policy Holder *_____Relationship to Patient * Self / Spouse / Parent / Other

Employer of Policy Holder_____

Secondary Insurance Company *_____ID # *_____

Group Number *_____Name of Policy Holder *_____

Date of Birth of Policy Holder *_____Relationship to Patient * Self / Spouse / Parent / Other

Employer of Policy Holder_____

POTOMAC PODIATRY GROUP, PLLC

Shruti A. Patel, DPM, MS, DABPM, AACFAS
Peter N. Brieloff, DPM, FACPM, FACFAS
Lyle T. Modlin, DPM, FACFAS
Alesia L. Madden, DPM
Vincent J. Bonini, DPM, FACFAS
Robert J. Toomey III, DPM, FACPM, FACFAS
Brittany E. Mayer, DPM, DABPM, AACFAS
Mark D. Dollard, DPM, DABPS, FACFAS
Tobias J. Glister, DPM, FACFAS
Jared C. Melman, DPM, AACFAS

SIGNATURE ON FILE

I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS.

I AUTHORIZE RELEASE OF PERTINENT INFORMATION TO ALL MY INSURANCE COMPANIES.

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR MY BILL.

I AUTHORIZE CROFTON FOOT AND ANKLE, A DIVISION OF POTOMAC PODIATRY GROUP, PLLC, TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM INSURANCE COMPANIES.

I AUTHORIZE PAYMENT DIRECT TO CROFTON FOOT AND ANKLE, A DIVISION OF POTOMAC PODIATRY GROUP, PLLC.

I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

WE OBSERVE A STRICT POLICY FOR CANCELLATIONS, RESCHEDULED APPOINTMENTS AND APPOINTMENTS MISSED WITHOUT 24 HOURS NOTICE AND WE RESERVE THE RIGHT TO CHARGE A $50.00 FEE *PLEASE INTIAL* * * *

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the notice.

Patient (or Guardian) Signature * _____

Patient Name (Please print) * _____ Date _____

Parent or Authorized Representative Name (if applicable) * _____

THANK YOU FOR CHOOSING CROFTON FOOT AND ANKLE

POTOMAC PODIATRY GROUP, PLLC

Shruti A. Patel, DPM, MS, DABPM, AACFAS
Peter N. Brieloff, DPM, FACPM, FACFAS
Lyle T. Modlin, DPM, FACFAS
Alesia L. Madden, DPM
Vincent J. Bonini, DPM, FACFAS
Robert J. Toomey III, DPM, FACPM, FACFAS
Brittany E. Mayer, DPM, DABPM, AACFAS
Mark D. Dollard, DPM, DABPS, FACFAS
Tobias J. Glister, DPM, FACFAS
Jared C. Melman, DPM, AACFAS

NEW PATIENT MEDICAL HISTORY

PLEASE ENSURE THAT ALL LINES ARE COMPLETE, PLEASE DO NOT LEAVE ANY SPACES BLANK

DATE:_____ **PATIENT NAME:**_____

SHOE SIZE:_____ **HEIGHT:**_____ **WEIGHT:**_____

DESCRIBE THE PROBLEM YOU ARE HAVING WITH YOUR FEET:_____

_____ **R L BOTH**

HOW LONG HAVE YOU HAD THESE SYMPTOMS?_____

Medication presently being taken? (Please provide dosage)

1)_____ **4)**_____

2)_____ **5)**_____

3)_____ **6)**_____

Supplements: (i.e./vitamins) 1)_____ **2)**_____

Are you allergic to: (Please indicate your reaction for ones checked yes)?

	YES	NO		YES	NO
Antibiotics			Sulfa		
Aspirin			Iodine, Shrimp		
Anesthetics			Tape		
Codeine			Motrin/Naprosyn		
Penicillin			Latex		
Other					

Have you ever had…?

	YES	NO		YES	NO
Anemia			Keloid/Thick Scar		
Arthritis (OA or RA)			Kidney or Liver Disease		
Asthma			Osteoporosis		
Blood Clot/Phlebitis			Psychiatric Disorder		
Cancer			Rheum. Fever		
Colitis			Sickle Cell Anemia		
Diabetes	Type 1 or 2		Stroke		
Epilepsy			Thyroid Disease		
Gout			Tuberculosis		
Hearing Problems			Ulcers or Reflux		
Heart Disease			V.D.		
High Blood Pressure			Vision Problems		
High Cholesterol			Other		

POTOMAC PODIATRY GROUP, PLLC

Shruti A. Patel, DPM, MS, DABPM, AACFAS
Peter N. Brieloff, DPM, FACPM, FACFAS
Lyle T. Modlin, DPM, FACFAS
Alesia L. Madden, DPM
Vincent J. Bonini, DPM, FACFAS
Robert J. Toomey III, DPM, FACPM, FACFAS
Brittany E. Mayer, DPM, DABPM, AACFAS
Mark D. Dollard, DPM, DABPS, FACFAS
Tobias J. Glister, DPM, FACFAS
Jared C. Melman, DPM, AACFAS

Any Medical Conditions in the immediate family (Diabetes, Arthritis, Heart Disease)?

_____

Have you ever had any major injury to the head, back, feet, or legs? (fractures, concussions) If yes, explain:

_____

Have you had any surgery? (list)

_____

Do you or have you in the past?
Smoke Cigarettes_____Drink Alcohol_____Take Drugs_____
(recreationally)

Do you participate in any athletic activity or exercise program?_____

Type of exercise:_____

How many days a week on average:_____

Average length of exercise sessions:_____minutes

Job Title:_____

Are you weight bearing at work?_____

_____
(standing, walking, any movement that requires you to be on your feet)

POTOMAC PODIATRY GROUP, PLLC

Shruti A. Patel, DPM, MS, DABPM, AACFAS
Peter N. Brieloff, DPM, FACPM, FACFAS
Lyle T. Modlin, DPM, FACFAS
Alesia L. Madden, DPM
Vincent J. Bonini, DPM, FACFAS
Robert J. Toomey III, DPM, FACPM, FACFAS
Brittany E. Mayer, DPM, DABPM, AACFAS
Mark D. Dollard, DPM, DABPS, FACFAS
Tobias J. Glister, DPM, FACFAS
Jared C. Melman, DPM, AACFAS

Dear Patient,

1. **INSURANCE/REFERRALS** - Patients must present appropriate insurance information and referral (if required) at the time of service or the visit will be rescheduled unless a waiver is signed. If your card does not have the appropriate information listed, or if a referral is required and not provided you will be responsible for your visit.

2. **CO-PAYMENTS AND DEDUCTIBLES** - Co-payments, co- insurances and deductibles must be paid at the time of service. In accordance with the terms of your contract with your insurance company. If you are unable to make these payments, arrangements may be made with our billing department prior to your next visit.

3. **NON-COVERED CHARGES** - Please note that in the event of a non-covered charge such as medical devices, OTC medications and supplies we have provided you with flexible payment options. Also, we will submit a claim on your behalf to your insurance for all billable charges.

To provide you with flexible payment arrangements, we have therefore expanded our payment policy. Payments can be made by cash, check, Visa, Mastercard and Discover by mail, calling into the office or on our website at www.croftonpodiatry.com.

Patient or Responsible Party Signature	Date
Patient Name (Please Print)	Responsible Party (Please Print)

POTOMAC PODIATRY GROUP, PLLC

Shruti A. Patel, DPM, MS, DABPM, AACFAS
Peter N. Brieloff, DPM, FACPM, FACFAS
Lyle T. Modlin, DPM, FACFAS
Alesia L. Madden, DPM
Vincent J. Bonini, DPM, FACFAS
Robert J. Toomey III, DPM, FACPM, FACFAS
Brittany E. Mayer, DPM, DABPM, AACFAS
Mark D. Dollard, DPM, DABPS, FACFAS
Tobias J. Glister, DPM, FACFAS
Jared C. Melman, DPM, AACFAS

Dear Patients,

This letter is to inform you of our updated billing practice in regards to receiving patient payments. **Effective January 1, 2020**, we now require a credit or debit card to be on file with our office.

Why the change?

With the changing environment in healthcare, more responsibility of payment is being placed on the patient such as co-insurances and deductibles. We need to be sure that patient balances are paid in a timely manner. To do this, we need to have a guarantee of payment on file in our office.

When is payment due?

All out of pocket expenses such as copays, co-insurances, deductibles, and non-covered services are due at the time of service. We are only able to collect an estimated amount when services are rendered and there may still be a patient balance once the claim is paid by the insurance company. Similar to hotels and car rental agencies, you are asked for a credit card number at the time you check in and the information will be held securely until your insurance company has paid their portion and notified us of the amount of your share. If there is a balance, your credit card will be automatically charged following the return of the insurance claim for any portion you are legally responsible to pay up to $75.00. If the charge exceeds $75.00 the office will notify the patient prior to the card on file being charged.

POTOMAC PODIATRY GROUP, PLLC

Shruti A. Patel, DPM, MS, DABPM, AACFAS
Peter N. Brieloff, DPM, FACPM, FACFAS
Lyle T. Modlin, DPM, FACFAS
Alesia L. Madden, DPM
Vincent J. Bonini, DPM, FACFAS
Robert J. Toomey III, DPM, FACPM, FACFAS
Brittany E. Mayer, DPM, DABPM, AACFAS
Mark D. Dollard, DPM, DABPS, FACFAS
Tobias J. Glister, DPM, FACFAS
Jared C. Melman, DPM, AACFAS

I,_____authorize Crofton Foot and Ankle to capture my credit card information and securely store my credit card on file. I authorize Crofton Foot and Ankle to charge my credit card on file for any balance $75.00 or less per visit. In the event the out of pocket costs exceeds $75.00 per visit the patient will be contacted prior to the charge taking place.

I agree Crofton Foot and Ankle may charge my credit card on file for the balance due when the EOB is received including copays, coinsurances, deductible, no show/cancellation fees and non-covered services.

I understand that all out of pocket expenses are due at the time of service and an estimate of out of pocket expenses are given and collected at that time.

I understand that this form is valid until I give a 30-day written notice to cancel the authorization. A written notice must be submitted to Crofton Foot and Ankle, 1657 Crofton Blvd, Suite # 201, Crofton, MD 21114.

I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Patient Name: _____
Card Holder Name (as shown in card):_____
☐Visa ☐MasterCard ☐Discover
Card Number:_____ Expiration Date:_____

_____

Cardholder Signature **Date**