Vale Foot & Ankle Surgery, PLLC

OXFORD - SHELTON - GLASTONBURY
Phone: (203) 941-6999
Fax: (203) 463-8308

Medicare and our network of private insurance companies require us to have photo ID and the insurance card on file. Acceptable identification includes the following: driver's license, non-driver's license, passport, government ID, military ID. You will not be seen without proof of identification.

Name: _____

Driver's License Number or SSN: _____

Date of Birth: _____ Gender: _____ Pronouns: _____

Email Address: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Insured's Name/DOB/SSN if different from above: _____

_____

Emergency Contact Name: _____ Phone: _____

Primary Care Physician Name: _____ Phone: _____

Primary Care Physician Address: _____

Who may we thank for this referral? How did you hear about us? _____

If the patient is a minor, name of person responsible for payment: _____

Address (if different from above): _____

Reason for today's office visit: _____

*If your visit is due to an injury, please give a brief description of what occurred:

_____

_____

Do you use tobacco products? Y __ N __ If yes, which product? _____

If cigarettes/cigars, how many packs/cigars per day? _____ For how many years? _____

Do you drink alcohol? Y __ N __ If yes, how many drinks per week? _____

Do you use recreational drugs? Y __ N __ If yes, which one(s)? _____ How often?_____

Occupation: _____ Employer: _____

Preferred Pharmacy: _____ Phone: _____

Drug or Food Allergies: _____

In the space below, please list your medications or provide a separate medication list. Please include the dosage and frequency. Please be sure to include over the counter vitamins.

_____

_____

_____

Please list any surgeries you have had in the past, including the date of surgery:

_____

_____

Please list your medical conditions: _____

_____

Have you ever tested positive for HIV? Y __ N __ Hepatitis C? Y __ N __ MRSA? Y __ N __

Family History:

[ ] Diabetes [ ] Heart Disease [ ] Cancer [ ] Thyroid [ ] High Blood Pressure [ ] High Cholesterol [ ] Other (List any others below. If you checked cancer, please elaborate below):

_____

VALE FOOT AND ANKLE SURGERY, PLLC Financial Policy:

We are committed to providing you with the best care. In order to achieve these goals, we need your assistance and your understanding of our payment policy. Payment for services are required at the time of service; therefore, at the time of your appointment. We accept payment in the form of cash, credit or debit card, or check. If you have insurance coverage with which we do not participate, we will process a claim after you have paid in full any balances due. Returned checks are subject to additional collection fees, including insufficient funds fees.

Balances older that 90 days are forwarded to a collection agency with additional fees.

1. Medicare patients: You are responsible for your annual deductible and 20% of what Medicare allows (coinsurance). We may ask you to sign a Medicare Advanced Beneficiary Form (ABN), which states that if Medicare does not cover a service or medical equipment, you understand that you will be responsible for the payment.
    a. Medicare patients only initial: _____
2. I agree that if my account falls delinquent, I will be responsible for all collection agency costs.
    a. Initial: _____
3. I authorize VALE FOOT AND ANKLE SURGERY, PLLC to submit all insurance claims on my behalf. I understand that I am responsible for all services not covered by insurance.
    a. Initial: _____
4. I understand all additional fees for which I may be responsible (listed below).
    a. Initial: _____

Medical Records Fee: The cost per page for medical records is $0.65.

No Show Fee: If you missed your appointment and did not call 24 hours ahead of time to cancel or reschedule, you will be subject to a No Show Fee of $50.00.

Check Insufficient Funds: If there are insufficient funds, you will be subject to a $40.00 fee.

Any questions about pricing should be addressed prior to any treatment being rendered.

Signature: _____ Date: _____

PARTICIPATING INSURANCES AND MEDICARE ASSIGNMENT: I authorize payment made on my behalf to VALE FOOT AND ANKLE SURGERY, PLLC for any services performed. I authorize the release of any medical information held by VALE FOOT AND ANKLE SURGERY, PLLC to the healthcare financing administration and its agents in order to process my claims.

Signature: _____ Date: _____

I, _____, hereby give permission to Vale Foot and Ankle Surgery, PLLC to administer, treat, and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the lower extremity condition. I also hereby assign Chelsea L. Viola, DPM and/or Khoa D. Nguyen, DPM all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am financially responsible for any balance due on my account ad a collection agency will be employed to enforce such. Furthermore, I have read and signed the financial responsibility form and understand the financial policy of Vale Foot and Ankle Surgery, PLLC. I understand this is a lifetime signature.

Federal Trade Commission Red Flag Policy:

One government form of picture identification is required before any treatment can be rendered to a registering new patient. If identification cannot be produced, treatment will be provided on an emergent basis only. In addition, the last five numbers of the patient's social security number and signature will be required before the release of any decal records. IF the patient has authorized other individuals to pick up medical information by denotating on the patient registration, their signatures and photo identification will be required before documentation will be released.

Privacy and Information Protection Policy:

Our office utilizes a HIPAA compliant Electronic Medical Record storage system. All data collected on this form is strictly used for insurance claim purposes and never shared with outside sources. All information not stored in the secured electronic storage format are shredded and disposed of properly. By signing below, you are acknowledging that you have either received a copy of our Privacy Policy or have been given access toa copy to review. It is understood that all durable medical equipment (DME) and products including, but not limited to creams, lotions, orthotics, arch supports, braces, pads, diabetic shoes, surgical shoes, crutches, can be purchased via an outside profession vendor. The products and in-office dispensing are for the convenience of the patient; therefore, financial responsibility will be solely on the patient. All payments for such services or devices are due upon the receipt of service or item unless other arrangements have been made in advance.

Signature of responsible party: _____ Date: _____

Printed name: _____