The Metropolitan Foot & Ankle Group

(a D/B/A of Michael H. Loshigian DPM PC)

New Patient Registration Form

Today's Date:_____

Patient Information:

Last Name:_____ First Name:_____ Middle Initial:_____

Sex: ☐M ☐F Age:_____ Date of Birth:_____ Social Security#:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Minor ☐Partnered

Home Address:_____ Apt:___ City:_____ State:____ Zip:_____

Contact Number: Cell:_____ Home:_____ Work:_____

Primary E-mail Address:_____

Employer/School:_____

Occupation:_____

Spouse's Name:_____ Date of Birth:_____

Primary Care Physician:_____ Last visit?_____

Pharmacy Name/Address_____City_____ Phone_____

Who may we thank for your referral?_____

Emergency Contact:

Full Name:_____ Relationship:_____

Primary Contact Number:_____ ☐Cell ☐Home ☐Work

Contact Preferences: (please check all that apply)

- I wish to be contacted in the following manner: ☐Cell ☐Home ☐Work ☐Email
- OK to leave a message with detailed information? ☐Cell ☐Home ☐Work ☐Email
- Leave a message with a call back number only? ☐Cell ☐Home ☐Work ☐Email

Insurance Information:

Who is responsible for this account:_____ Relation to patient:_____

Insurance Co.:_____ ID#:_____ Group#:_____

Are you covered by additional insurance? ☐Yes ☐No Insurance Co.:_____ ID#:_____

Subscriber's Name (if other than patient):_____ Birth Date:_____ Relation:_____

Do you have a Health Savings Account (HSA) or a Flexible Spending Account (FSA)? ☐Yes ☐No

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Patient Name:_____

PLEASE INITIAL EACH OF THE FOLLOWING

Financial Agreements:

_____ Insurance Assignment and Release

I certify that I have coverage with the above mentioned insurance company(ies), assign all insurance benefits directly to a provider at The Metropolitan Foot & Ankle Group, if any, otherwise payable to me for services rendered, and authorize payment of all commercial insurance benefits or Medicare benefits to The Metropolitan Foot & Ankle Group for services received. The Metropolitan Foot & Ankle Group may use my health care information and may disclose such information to the above mentioned insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. **I understand that I am financially responsible for all charges, whether or not paid by my insurance company.** I authorize the use of my signature on all insurance submissions.

_____ Insurance Conditional Coverage Request

Effort has been made to verify your eligibility and benefits for medical services, procedures, orthotics, prosthetics, and/or durable medical equipment (DME) coverage with your insurance company. You are requested to initial above in the event that you do not have proper coverage for the services received at The Metropolitan Foot & Ankle Group. **If it is determined that you are not covered by your insurance company(ise) for our services or products, you will be financially responsible for those services and/or products, without refund or credit.** If your insurance company denies payment, regardless of prescription or authorization, then you will be financially responsible, without refund or credit. Dispensed items are non-returnable due to health, hygienic and medical safety regulations; but adjustments or re-make services may be covered within the first 90 days. Any additional work, services, or products will result in extra charges. **The Metropolitan Foot & Ankle Group requires a deposit of 50% for any non-covered or out-of-pocket item/service.**

_____ Credit Card on File

By initialing above, I authorize The Metropolitan Foot & Ankle Group to keep my signature and my credit card information securely on-file in my account. **I authorize The Metropolitan Foot & Ankle Group to charge my credit card for any outstanding balances when due.** If the credit card that I give today changes, expires, or is denied for any reason, I agree to submit a new and valid credit card which I also allow to be charged.

You have the option of not leaving a credit card on file. Once your insurance Explanation of Benefits is received and posted to your account, you will be sent a statement showing your financial responsibility. You will have 30 days to send an alternative form of payment for services rendered. To fabricate, mail, and process your statement, we reserve the right to charge your account a $15 monthly statement fee.

By signing below, I acknowledge that I have read this form and I understand that if I am not eligible for service coverage with my insurance company, I will be held financially responsible for services rendered. If I choose not to leave a credit card on file, I will be charged a $15 monthly statement fee instead. We require that payment of deductibles, copays, surgery deposits, non-covered items, and co-insurance be paid at the time of service.

Name of Patient:_____ **Date:**_____

Signature of Patient/Guardian:_____ **Relation to Patient:**_____

The Metropolitan Foot & Ankle Group

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Patient Name:_____

PLEASE INITIAL EACH OF THE FOLLOWING

Office Agreements:

_____ **Disclosure of Medical Information:**

By initialing above, I hereby give permission to The Metropolitan Foot & Ankle Group to disclose and discuss any information related to my medical conditions to/with the following individuals (relatives or close personal friends):

Full Name:_____ Relationship:_____

Full Name:_____ Relationship:_____

☐ I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my medical condition(s).

_____ **Notice of Privacy Practices:**

By initialing above, I hereby acknowledge that I have received the foregoing Notice of Privacy Practices for protected health information, I have been provided an opportunity to review it, and understand its terms. I also acknowledge that if I would like further information regarding my protected health information, my rights, or the office's obligations under HIPAA, I can contact the Privacy Officer at 718-380-7900.

_____ **Facsimile (Fax) Authorization for Coordination of Care:**

By initialing above, I authorize The Metropolitan Foot & Ankle Group to send/receive confidential healthcare information, as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164), by facsimile (fax) to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of my care. Medical records requests require a separate form and authorization from this Facsimile Authorization. I may revoke this authorization by giving The Metropolitan Foot & Ankle Group five (5) days written notice. This revocation may be by facsimile transmission; however, a written copy of the revocation must be mailed to The Metropolitan Foot & Ankle Group as well.

_____ **Automated Appointment Reminders:**

By initialing above, you consent to receive messages via phone, email, and/or text as appointment reminders. The Metropolitan Foot & Ankle Group has adopted an automated appointment reminder system which will send you **appointment confirmation requests via e-mail 5 days prior to your appointment, a text message 2 days prior, and an automated phone call the day before your scheduled appointment**. The system will not disclose your protected health information with any third parties.

_____ **24 Hour Cancellation & "No Show" Fee Policy:**

We reserves the right to charge a **fee of $75.00 for all missed appointments** ("no shows") and appointments which, absent a compelling reason, are **not cancelled with a 24-hour advance notice (or by 5pm on Friday for a Monday appointment)**. By initialing above, you acknowledge that you have received this notice and understand that the "no show" fee will be billed to you, that this fee is not covered by insurance, and the fee must be paid prior to your next appointment.

_____ **Prescription Refill Policy:**

Prescriptions will only be written and refilled from Monday through Friday 8:00 am to 5:00 PM. Therefore, it is your responsibility to closely monitor your supply of medications. We recommend that you make your prescription requests at least 48 hours prior to running out of your prescriptions. By initialing above, you acknowledge that you have read and understand this information.

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Patient Name:_____

_____ Disability Forms Processing Policy:

By initialing above, you acknowledge that you have read and understand this information. **All Private Insurance Disability forms, Life Insurance forms, FMLA forms, and Worker's Compensation forms will require a $30.00 fee due at the time forms are submitted to our office.** Please note that any **paperwork processed by this office will take up to 5 business days** (from the date received) to complete and mail. If you would like us to fax it to your Employer/Insurance Company/Outside Agency, please provide their fax number. Paperwork cannot be processed unless you have completed all portions of the document that are to be filled out and signed by you. A copy of your paperwork will be placed in your chart after the doctor signs it and will remain a part of your permanent record. This applies to all forms. Paperwork will not be processed without payment in advance. We accept cash, checks and credit cards.

_____ Request and Consent to Photography and/or Video Recording:

Your doctor may need to photograph (and/or record) your foot to document a medical condition, help with the diagnosis and/or treatment of a condition, and/or help plan details of surgery. Photographs and/or recordings taken for these clinical reasons do not require your written permission. **Your provider does need your written permission to use your photographs and/or video recordings for non-clinical reasons, including but not limited to, teaching, research, medical education, lectures, presentation, commercial broadcasts, and/or in marketing materials, if applicable. By initialing above, I understand and agree that my name, any personally identifiable information, and any protected health information will not be displayed if my photographs and/or videos are used for non-clinical reasons.**

_____ Patient Request for Email/Text Communications:

By initialing above, you acknowledge that you have read and understand this information and that the email and cell phone number provided on this registration form are accurate. As a patient of The Metropolitan Foot & Ankle Group, you have the right to request we communicate with you by electronic mail (email) and/or text messaging (text). Email and/or texts on your computer, your laptop, and/or your personal electronic devices have inherent privacy risks. These communication methods are not HIPAA compliant. **I understand that communication over email or text may not be sent securely, may not be encrypted, and that there is no assurance of confidentiality of information when communicating this way. I understand the risks associated with that including, but not limited to, that my personal health information (PHI) may be read by an unintended third party. I have been notified of the risks. I understand said risks and I still prefer to receive communication via email or text.** I understand that The Metropolitan Foot & Ankle Group and its staff are not responsible for any unauthorized access of my PHI communicated by way of email and texts, and that I bear the risk.

☐ I choose to waive the option for any email and/or text communication with The Metropolitan Foot & Ankle Group

By signing below, I acknowledge that I have read, understood, and I agree (as indicated by my initials) with the above mentioned policies of The Metropolitan Foot & Ankle Group.

Name of Patient:_____ **Date:**_____

Signature of Patient/Guardian:_____ **Relation to Patient:**_____

The Metropolitan Foot & Ankle Group

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Patient Name:_____

ADVANCE NOTICE FOR MEDICARE BENEFICIARIES

MEDICARE WILL NOT PAY FOR CERTAIN FOOT CARE SERVICES AND ITEMS

When you receive foot care services and items that are not Medicare benefits, you are responsible to pay for them personally or through any other insurance that you may have. Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits. **When services or items are not Medicare covered benefits, Medicare will not pay for them.**

The purpose of this advance notice is to help you make an informed choice about whether or not you want to receive these foot care services or items, knowing that you will have to pay for them yourself. **We do not send claims to Medicare for foot care services or items that are always excluded from Medicare coverage.**

Before you make a decision, you should read this entire notice carefully.

- The Medicare program does not cover most routine foot care and flat foot care. **Medicare law clearly excludes coverage for services in connection with "the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care." Medicare law clearly excludes coverage for services in connection with "treatment of flat foot conditions and the prescription of supportive devices thereof" or with "the treatment of subluxations of the foot."**
    - A narrow exception permits coverage of some foot care services when certain conditions result in severe circulatory problems or areas of diminished sensation.
- The **Medicare program does not cover most orthopedic shoes or other foot supports (orthotics).** Medicare law clearly excludes coverage for services in connection with "orthopedic shoes or other supportive devices for the feet."
    - A narrow exception permits coverage of special shoes and inserts for certain patients with diabetes.

For patients with Medicare, this means that Medicare will not pay for most routine foot care, flat foot care, orthopedic shoes, or orthotics, because they are not Medicare covered benefits. Payment for these excluded foot care services and items is your responsibility.

If you have any additional questions concerning Medicare coverage for foot care services or items, you can contact Medicare at 1-800-MEDICARE (1-800-633-4227).

Name of Patient:_____ **Date:**_____

Signature of Patient/Guardian:_____

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Patient Health History Questionnaire

Last Name:_____ **First Name:**_____ **Date of Birth:**_____

Past Medical History

- ☐ Acid Reflux
- ☐ Alzheimer's Disease
- ☐ Angina
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots / DVT
- ☐ Cancer_____
- ☐ High Cholesterol
- ☐ Chemical Dependency
- ☐ Congestive Heart Failure
- ☐ Crohn's Disease/IBS
- ☐ Diabetes – Type ____
- ☐ Emphysema/COPD
- ☐ Gout
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Herpes Zoster
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ HIV or AIDS
- ☐ Kidney Problems

☐ **NO Past Medical History**

- ☐ Low Blood Pressure
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Lupus
- ☐ Mental Illness
- ☐ Morbid Obesity
- ☐ Neuropathy
- ☐ Phlebitis
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Swollen Glands
- ☐ Sleep Apnea
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Weight Loss
- ☐ Other_____

Past Podiatric Medical History

- ☐ Ankle or Foot pain
- ☐ Athlete's Foot
- ☐ Arthritis
- ☐ Bunions
- ☐ Bursitis
- ☐ Cerebral Palsy
- ☐ Corns/Calluses
- ☐ Cellulitis/Infection
- ☐ Dislocations_____
- ☐ Fibromyalgia
- ☐ Flat Feet
- ☐ Fractures_____
- ☐ Foot or Leg Cramps
- ☐ Ganglion Cyst
- ☐ Heel Pain
- ☐ Heel Spur

☐ **NO Past Podiatric Medical History**

- ☐ Herniated Disc
- ☐ Ingrown Toenails
- ☐ Multiple Sclerosis
- ☐ Neuroma
- ☐ Numbness in Feet
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pain – Back
- ☐ Pain – Knee
- ☐ Psoriatic Arthritis
- ☐ Plantar Warts
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Sprains/Strains____
- ☐ Swelling of Joints
- ☐ Tarsal Tunnel Syndrome

Past Surgical History

☐ **NO Past Surgical History**

Surgery(ies) you have had in the past:_____

_____

_____

Family History

☐ **NO Family History**

- ☐ Alcoholism
- ☐ Stroke
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Gout
- ☐ Hypertension
- ☐ Mental Illness
- ☐ Other_____

Work Status: ☐ Disabled ☐ Homemaker ☐ On Leave ☐ Retired ☐ Student ☐ Unemployed ☐ Working

Alcohol use? ☐ No Alcohol ☐ Yes, consume alcohol (___ drinks per day) ☐ Social Drinker

Tobacco use? ☐ Never ☐ Current everyday ☐ Current occasional ☐ Formerly (Quit _____ years ago)

Recreational drug use?: ☐ Never ☐ Currently ☐ In the Past

Are you Pregnant? ☐ Yes ☐ No

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Patient Name:_____

Do you have any Drug Allergies?:

☐ Adhesive/Tape ☐ Aspirin ☐ Blood Thinners ☐ Codeine ☐ Iodine ☐ Local Anesthetics
☐ Penicillin ☐ Shellfish ☐ Sulfa ☐ Other_____

Are you currently taking any medications?_____

_____

_____

Chief Complaint: What is the main reason for your visit today? Describe the problem in detail. (What Hurts?)

_____

_____

_____

Side: ☐ Left ☐ Right ☐ Both **Area with most pain?** ☐ Toes ☐ Top of Foot ☐ Bottom of Foot ☐ Ankle

How long have you had pain? Weeks____ Months____ Years____ **Date of Injury**(if applicable):_____

Is this injury: ☐ Work related? ☐ Motor Vehicle Accident related? ☐ Sports related? ☐ Trauma related?

What is your pain quality? ☐ Dull ☐ Sharp ☐ Achy ☐ Burning ☐ Stabbing ☐ Tingling ☐ Soreness

When is pain the worst? ☐ Morning ☐ Evening ☐ After Activity ☐ At Night (interferes with sleep)

Pain Level: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What actions/activities make the problem worse?

☐ Walking ☐ Standing ☐ Running ☐ Bending ☐ Lifting ☐ Reaching ☐ Driving ☐ Sitting
☐ Other:_____

What actions/activities make the problem better?

☐ Resting ☐ Ice ☐ Heat ☐ Elevation ☐ Pain Meds ☐ Activity ☐ Other_____

Are there any other associated signs or symptoms?

☐ Weakness ☐ Numbness/Tingling ☐ Radiating Pain ☐ Instability

Have you had any diagnostic studies or treatments for this problem? If so, when and where?

☐ X-Ray ☐ MRI ☐ EMG/NCV ☐ CT ☐ Ultrasound ☐ Physical Therapy ☐ Injections ☐ Bracing
☐ Surgery_____ ☐ Other_____

Are there any specific treatment options that brought you to us?

(i.e. Stem Cell, Visco-supplementation, PRP, Laser Treatment, Orthotics, etc…)

_____

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Patient Name:_____

REVIEW OF SYSTEMS

Please check any symptoms that you are currently experiencing.

☐ NONE of the below

Constitutional: ☐ Chills ☐ Fever ☐ Headache ☐ Weight Gain/Loss ☐ Fatigue ☐ Body Ache

Cardiovascular: ☐ Chest Pain ☐ Hypertension ☐ Palpitations ☐ Varicosities ☐ Rapid Heart Rate

Genitourinary: ☐ Urine Hesitancy ☐ Incontinence ☐ Urinary Retention ☐ Hematuria

Musculoskeletal: ☐ Back Pain ☐ Joint Swelling ☐ Joint Pain ☐ Neck Pain ☐ Ankle Instability
☐ Joint Stiffness ☐ Muscle Cramps ☐ Leg Cramps ☐ Muscle Weakness

Hema-Lymph: ☐ Anemia ☐ Blood Clotting ☐ Swollen Glands ☐ Easy Bruising

HEENT: ☐ Sore Throat ☐ Ear Infection ☐ Nasal Congestion ☐ Nose Bleeding ☐ Blurred Vision

Respiratory: ☐ Shortness of Breath ☐ Wheezing ☐ Cough

Gastrointestinal: ☐ Abdominal Pain ☐ Constipation ☐ Jaundice ☐ Diarrhea ☐ Nausea/Vomiting ☐ Ulcers

Integumentary: ☐ Boils ☐ Itching ☐ Redness ☐ Skin Rash ☐ Open Wound

Neurologic: ☐ Blackouts ☐ Dizziness ☐ Tingling/Numbness ☐ Seizures ☐ Tremors ☐ Sciatica

Endocrine: ☐ Excessive Thirst ☐ Tired ☐ Too Cold/Hot

Psychiatric: ☐ Depression ☐ Difficulty Sleeping ☐ Anxiety

Allergic/Immunologic: ☐ Drug Allergies ☐ Hay Fever ☐ Runny Nose

FOR OFFICE USE ONLY:

Treatment Consent: I hereby consent and give my permission to the doctor (and doctor's assistant or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Name of Patient:_____ Date:_____

Signature of Patient/Guardian:_____ Relation to Patient:_____