Paula F. Angelini DPM
Board Certified Foot Care, LLC
P (508) 226-8070 F (508) 223-3498

Southboro
162 Cordaville Road Suite 185
Southborough, MA

Attleboro
140 Park Street Suite 1
Attleboro, MA

Foxboro
40 Mechanics Street
Foxboro, MA

Name: _____

Address: _____

Phone (home): _____ (cell): _____

**Email: _____

Sex: M/F Age: _____ Date of Birth: _____

Occupation: _____

Emergency Contact: _____

**Primary Care Doctor: _____ Phone: _____

Address: _____

Who may we thank for referring you to our office? _____

Responsible Party for Patient: _____

Relationship: _____ Phone: _____

Authorization:

I hereby authorize Board Certified Foot Care to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign all payments to Board Certified Foot Care for medical services rendered to myself or my dependents. I am aware that it is my obligation to know my Insurance companies policies and that I am responsible for payments if I have not fulfilled their requirements.

I hereby request and voluntarily consent to podiatric care, including but not limited to routine nail/ skincare, diagnostic procedures, radiographs as needed, other treatments deemed necessary by Dr. Angelini and Associates.

Signature: _____ Date: _____

Patient Responsibility

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service, routine examination, refraction, testing, and any other screening ordered by the doctor.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has a deductible, co-payment, co-insurance, out of network, usual & customary limit, prior authorization requirements or any other type of benefit limitation for the services, and I agree to make payment in full.

I understand and I agree that it is my responsibility to know if my insurance requires a referral from my primary care physician, and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services, and I will be responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree I am financially responsible for the balance in full.

If I am a Medicare patient I understand I need to provide the office with both my Medicare ID card, and my secondary insurance card. If office does not have full secondary insurance information, it will not be billed. It will be my responsibility to pay the balance, and then file a claim with the secondary insurance for reimbursement.

By signing this form, I consent to use and disclosure of protected health information about me for treatment, payment and health care operations, and /or as required by law. I have the right to revoke this consent, in writing, and signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. LLCEA/PS provides this form to comply with the Health Insurance Portability and Accountability Act of 1996(HIPPA).

Full Name:_____ Relationship to patient:_____

Signature:_____ Date:_____

I give permission to communicate my Private Healthcare Information to:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Medical History

Do you have or have you had any of the following:

	Yes	No		Yes	No
Diabetes:	___	___	Arthritis:	___	___
Asthma:	___	___	Clotting Disorder:	___	___
Cancer:	___	___	Excessive Bleeding:	___	___
Fibromyalgia:	___	___	GI Bleed:	___	___
Hepatitis:	___	___	Ulcer:	___	___
HIV/AIDS:	___	___	High BP:	___	___
Renal Failure:	___	___	Low BP:	___	___
Stroke:	___	___	Thyroid Disease:	___	___
Heart Attack:	___	___	Tissue Disorder:	___	___
CHF:	___	___	Joint Pain:	___	___
Leg Cramps:	___	___	Muscle Pain:	___	___
Weight changes:	___	___	Joint Pain:	___	___
Respiratory Disorder:	___	___	Murmur:	___	___

Other: _____

Do you have, or have you had any changes in the following:

	Yes	No		Yes	No
Edema:	___	___	Prolonged healing:	___	___
Trouble breathing:	___	___	Burning of skin:	___	___
Cold Feet:	___	___	Difficulty walking:	___	___
Diarrhea:	___	___	Heartburn:	___	___
Dry Skin:	___	___	Nausea:	___	___
Urinary Difficulty:	___	___	Numbness:	___	___

Are you currently pregnant and/or think you could be pregnant? Y/N

Do you use any illegal/or illicit drugs? Y/N Do you currently smoke/vape nicotine? Y/N

What is the nature of your visit today?

_____

_____

Do you have any allergies to: (Please circle Y for yes & N for No)

Adhesive tapes: Y/N Latex: Y/N Codeine: Y/N Erythromycin: Y/N

Aspirin: Y/N Penicillin: Y/N Other: _____

Are you taking any prescription and/or over the counter medications? If so please list Medication/Dosage/Frequency:

_____

_____

_____

Name, Address, & Phone # of your pharmacy: _____

_____

_____

_____

Have you had any surgeries in the past? If so please list date & type of surgery:

_____

_____

_____

Family Medical History:

Blood Clots: Y/N Charcot-marie tooth: Y/N Diabetes: Y/N

Gout: Y/N Hypertension: Y/N Liver Disease: Y/N

Seizures: Y/N Stroke: Y/N Cancer: Y/N

DVT: Y/N Eczema: Y/N Heart Disease or malfunction: Y/N

Kidney Disease: Y/N Arthritis: Y/N Stomach Ulcer: Y/N

Migraines: Y/N Other: _____

OFFICE POLICY

We would like to welcome you to our office. Please Take the time to look at our office policies regarding patient responsibility; then sign & date.

1. All Copayments are due at the time of service/visit. If not paid at the time of service/visit, there will be a $5.00 additional fee charged.

2. We require a 24 hour notice for appointments to be cancelled & rescheduled. There will be a $50.00 charge for late cancellation and NO-SHOW appointments.

3. It is your responsibility to know your insurance and how it works:

   - You are responsible to obtain insurance referral if needed, from your Primary Care Doctor.
   - You are responsible for your insurance deductible, if you have one.
   - You are responsible to let this office know of any insurance changes.
   - You will be responsible for any and all charges not covered by your insurance

I have read, been informed of, and understand this policy.

Name:_____ Date:_____

The staff will be happy to assist you with any questions or concerns you may have.

Thank You!