BENENATI FOOT AND ANKLE CARE CENTERS
Welcome to our Office!!!

FULL NAME: ____ BIRTHDATE: ___/___/____ SEX: male or female

Patient SSN: ____________________________ MARITAL STATUS: *SINGLE* *MARRIED* *DIVORCED* *WIDOWED* *SEPARTED*

ADDRESS: _______________________________ CITY: __________________________ STATE:__________ZIP: _______________

HOME PHONE: (______)________________ CELL: (______)______________ WORK: (______)_________________

EMAIL: ____ OCCUPATION: ____

EMERGENCY CONTACT NAME & PHONE _______________________________________ RELATION: __________

PREFERRED METHOD FOR APPOINTMENT REMINDERS: *HOME* *CELL* *TEXT* *EMAIL*

Insurance and Responsible party Information:

Primary Insurance:______________________________ ID Number: ____________________

Subscribers Name: _____________________________ Subsrcribers Birthdate: ____________

Secondary Insurance: ___________________________ ID Number: ____________________

2ndary Subscribers Name: ________________________ Birthdate : ____________________

If the patient is a minor who will be responsible for payment:

Full Name: ________________________________ Relationship to the patient:________________________

Billing Address: ___________________________________City: ______________________ State: _______ Zip: __________

Is this injury related to a workers compensation claim or auto accident? If yes... Whom do we contact phone # __________________

The name of the insurance company___________ Date of Injury: ___________ Claim #:________________Is this claim Open? ________

Pharmacy Name: ___________________________________ Pharmacy phone #: __________________________

Cross Roads or Address of your pharmacy: ____

How were you referred to our Office? *Doctor / Internet / Sign / Family or Friend / Other:* ___________________________

Name of your primary Care Physician: ______________________________ Phone # ________________ Fax # __________________

Primary care Address: _________________________________ Hospital Affiliation:_______________________

Are you diabetic? YES NO If yes, the name of your treating physician: _________________________

OVERALL HEALTH: GOOD / FAIR / POOR HEIGHT: ________ WEIGHT: ________

Please Circle any of the following that apply:

Constitutional	Eyes	Ear, Nose & Throat
Fever Weight Loss Lethargy None	Blurred/Double Vision Cataracts Glasses and/or Contacts Legally Blind None	Tinnitus Nose Bleeds Nasal Congestion Sore Throat Difficulty Swallowing None
Respiratory	**Cardiovascular**	**Skin**
Chronic Cough Wheezing Emphysema Cough Blood Productive Cough Asthma None	Shortness of Breath Chest Pain (Angina) Heart Palpitations Heart Attack Stroke Cold Extremities Calf Pain High Blood Pressure (Hypertension) Lower Extremity Swelling None	Itching Lumps Rash Dry Skin Calluses Erythema Fungal Nails Ingrown Toenails Open Lesions None
Neurologic	**Musculoskeletal**	**Gastrointestinal**
Dizziness Memory Loss Weakness Fainting Headache Numbness Tingling Seizures None	Limited Range of Motion Pain (musculoskeletal) Limited Strength Foot Deformity Arthritis None	Heartburn Diarrhea Food Intolerance Nausea Blood in Stool Blood in Vomit Loss of Appetite Constipation Change in Stool Mucus in Stool Pain (Gastro) None
Genitourinary	**Hematologic/ Lymphatic**	**Endocrine**
Urinary Frequency Abnormal urine color Unable to fully Empty Bladder Blood in Urine Painful Urination On Hemodialysis Incontinence Awaken to Urinate None	Easy Bruising Blood Thinners Anemia Lymph Node Enlargement Blood abnormalities None	Night Sweats Thyroid Disease Diabetes None

WHAT CONCERNS DO YOU have regarding your feet? ________________________________

Are you a Diabetic? Yes or No

If Yes: Type I or Type II

Last A1C: ________ Last Blood Sugar: __________

Immunizations:

Influenza.......... Date: _________

Pneumonia........ Date: _________

Tobacco Use:

Previous Smoker/Never Smoked

Chew Tobacco

Smoke Cigarettes

E-Cigarettes/Vape

Alcohol Use:

Never Alcohol Use

Social Alcohol Use

Heavy Alcohol Use

Previous Alcohol Use

Drug Use:

Illegal Drug Use

Previous Drug Abuse

Current or Previous Opioid Abuse

No Drug Use Marijuana Use

PAST MEDICAL HISTORY:

Hepatitis hypertension asthma anemia arthritis Cancer Diabetes DVT Bleeding tendencies cholesterol

emphysema gout Glaucoma hypoglycemia heart/circulation trouble epilepsy HIV/AIDS Kidney Disease

liver disease leg cramps nervousness stroke tumors Tuberculosis thyroid disease ulcers varicose veins

Other:________________

FAMILY HISTORY:

Diabetes Arthritis Stroke Hypertension Bleeding Disorders Heart conditions Respiratory Disorders Cancer

Other: ___________________

ALLERGIES: Do you have allergies to any medications?

Penicillin Sulfa Codeine Demerol Aspirin Novocain Eggs Tetracycline Darvon Cipro Seconal Tetanus Anesthetics

Antihistamines Keflex Other:____

ARE YOU ALLERGIC TO LATEX PRODUCTS: YES NO

CURRENT MEDICATIONS: Please List all prescription medications you are taking, include dosage and frequency. (Insulin, inhalers and patches should be included): ____

____

____

NON-Prescription medications you take routinely *(ex. Vitamins, supplements) :*

____

____

Please list any Surgical Procedures you have had in the past: __________________________________

INFORMATION / FINANCIAL RESPONSIBILITY / ASSINGMENT AND RELEASE

How may I pay?
We accept payment by Cash, Check, Visa, MasterCard, Discover, American Express & Care Credit either in person, by mail or over the phone. Self pay patients will be required to pre-pay a deposit of $150.00, once seen and services rendered the balance is expected prior to leaving the office. Statement less than $5.00 will not be mailed, however they will remain your responsibility. Please call our office if you have questions regarding your statement. Statements will be mailed monthly, you may call the office to make your payment or by mail. Accounts over 90 days will be transferred to a Collection Service, please do not wait as once they have received this, we will not be able to make payment arrangements.

Do I need a referral or pre-certification?
If your insurance plan requires a referral authorization from your primary care physician or pre-certification from your insurance, you are responsible for contacting your PCP or insurance company to be sure it has been obtained. If we have not received an authorization prior to your arrival at the office, your appointment WILL be rescheduled, as a participating provider we will need the authorization for you to be seen.

Which plans do you contract with?
Benenati Foot & Ankle Care Centers accepts most major insurance plans. However, it is always best that you check with your insurance that you have chosen to see a provider in-network with your insurance. It is also your responsibility to let our office know if any labs are required by your insurance to be sent to a specific lab.

Why do I have to pay my co-pay and/or deductible?
When you signed up with your insurance carrier, you basically signed a contract which stipulates that you are obligated to pay your copay and/or deductible in certain instances. That usually means that you are required to pay for office visits, including follow-up examinations, outpatient surgical procedures done in our office, etc. **Payment for all copay/deductibles are expected at the time services are rendered, a $15 late fee will be applied on your 2nd statement if no payment has been collected within 30 days of the initial notice.** Collections upfront reduce administrative costs and become a savings to you, the patient.

What is my financial responsibility?
Our office will submit your claims to your insurance company as a courtesy service to you. It is your responsibility to know what services you insurance plan covers; we take no responsibility to know what your plan covers. Services that we render that are not covered by your insurance company, including lab fees, DME and surgical procedures, non-covered benefits or out of network benefits, are your responsibility. Please be sure to notify us if your insurance requires labs to be sent to a specific lab company to avoid excessive costs to yourself. We emphasize, as your health care provider, that our relationship is with you and NOT with your insurance company. Patients without insurance will be responsible for payment in full prior to treatment being rendered. Please contact the office for Medical Records and fees for personal records requests.

What if I miss my appointment?
We understand there may be times we forget or something happens that we cannot make a scheduled appointment. Please understand that repeat offenders of this will be charged a $55 fee for all appointments that have NOT been cancelled/rescheduled within 24 hours of the appointment. 3 or more no shows or continually late to a scheduled appointment may be grounds for dismissal from our care.

What if my child needs to see the physician?
A parent or legal guardian must accompany patients who are minors on the patient's first visit. If a procedure is to be performed, a parent or legal guardian must be present to sign the consent form. This cannot be any other adult or authorized representative for the patient. If a minor is going to be accompanied by someone over 18 that is not a parent or legal guardian, there must be a written note from the parent or legal guardian giving the authorized adult permission to bring the minor to the appointment.

Work Injuries:
If you have suffered a work injury and the claim will be submitted to a Workman's Comp Plan, it is your responsibility to provide our office with the name of the adjuster and their phone #, a claim number, date of injury, and claim address. This information must be given to our office prior to your appointment so we can verify that the claim is open and billable and what body parts are covered under that claim.

FMLA/DISABITLITY/WORK FORMS:
You may need to take off from work or school, due to an injury or surgery or other reasons. Our office will fill out the necessary paperwork for the provider portion of these forms. The **fee is $25.00** and some paperwork may take 7-14 days to complete. You will be contacted when they have been completed. If you need copies of medical records, please contact the medical records department for fees, depending on the length of time required to obtain these records, or if the records are available.

I have read, understand and accept the above statements. I certify that I (or my dependents) have insurance and assign payment directly to Anthony V Benenati DPM PC, all insurance benefits, if any, otherwise billable to me for services rendered. I understand that I am personally responsible to pay all charges that are not covered by my insurance, including but not limited to, copays, deductibles, co-insurance and non-covered services. I consent to having my blood drawn and being tested for Hepatitis and HIV if doctor and/ or staff are exposed to my blood and/or fluids. I hereby authorize the doctors to release information necessary to secure payment of benefits. I authorize the use of this signature on all insurance claims submissions. I agree that I may be charged reasonable collection fees and attorney fees if the office is forced to refer my past due account to collection and/ or an attorney.

Print Patient Name:________________________________ **Patient Signature**: ________________________________Date: ____________

Parents/Legal Guardian Signature:____Date: ___________

OFFICE COPY

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to Used or Disclosed:
The information covered by this authorization includes:
All medical and/or related issues pertaining to my diagnosis and/or care.

Information described may be disclosed by:
Benenati Foot & Ankle Care Centers
Anthony Benenati, DPM, PC and/or Staff

Persons to Whom this office may disclose or release your health information to:
example: self only/daughter/son/spouse/pcp or others. Name & relationship

____

Name of Person or Organization (Your relationship to this person)

____

Name of Person or Organization (Your relationship to this person)

Expiration Date of Authorization:
This authorization is effective until such times it is revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization:
You may revoke or terminate this authorization by submitting a written revocation to Anthony V Benenati, DPM, PC. You should contact the Privacy and Security Officer to terminate this authorization.

Potential for Re-disclosure:
Information that is disclosed under this authorization may be disclosed again by the person or origination to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

____

Print Name of Patient

____

Signature of Patient Date

____

Signature of Parent or Legal Guardian

____

Relationship to Patient

PATIENT SPECIALIST PARTNERSHIP AGREEMENT

Our goal at **Benenati Foot and Ankle Care Centers** is to provide you the best care possible. This can happen by using us as your Patient Centered Specialty Care Doctor/Patient Centered Medical Home (patients take an active role in their health care, working closely with both their PCP & Specialist). We work with your Primary Care doctor and below are some important things to remember as we partner to better healthcare!

PATIENTS Please:

- Follow up with your Primary Care Doctor as directed
- Make and keep all appointments with our office and with your Primary Care
- Ask questions until you know what you need to do when you leave our office.
- If you must cancel and appointment, make another one as soon as possible.
- Follow the plan we talked about during your appointments
- If you are not able to follow the plan, tell us so we can help make other arrangements
- Provide our office with your most up to date health information, including medications
- Completing diagnostic test (lab, xray,mri etc)

SPECIALIST DOCTOR:

- We will ask you who your Primary Care doctor is and let them know about your care as soon as possible.
- We will talk with you about your health and what you need to do to take care of yourself
- We will talk to you by phone and in the office to answer your questions/concerns.

Thank you for partnering with our office and taking an active role in your health. In order to enhance our partnership it is important we share some helpful practice information. Feel free to visit the web site for hours, locations and information at www.benenatifootcare.com

You may reach the office Monday-Friday 9-5pm, we offer 24 hour answering service before and after hours.

586-779-6140-St Clair Shores	**27593 Harper Ave, St Clair Shores**
586-416-3668-Macomb	**46591 Romeo Plank, #104, Macomb**
586-756-3338-Warren	**26440 Hoover Rd,# B, Warren**

Please call the office for prescription refills. To avoid delays and issues, please have your prescription name and dosage available, as well as, the pharmacy name and phone number that we need to send it to.

Should you have a life threatening emergency please proceed to the nearest hospital or Urgent Care (see list) and contact our office for follow up the next business day.

Macomb Twp Urgent Care: Ascension Urgent Care 18200 23 Mile Rd & Romeo Plank, Macomb
Warren: Urgent Care Clinic 30736 Hoover, Warren
St Clair Shores: Ascension Urgent Care Clinic 21000 E. Twelve mile Rd, St Clair Shores

Once again, we appreciate the trust you have given us to provide the best possible care!

Benenati Foot and Ankle Care Centers
Anthony V. Benenati DPM, Neil T. Shaw DPM and Mckenna Green DPM

~ PATIENT COPY TO KEEP ~

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