BENENATI
FOOT AND ANKLE CARE CENTERS

Welcome to our office!

FULL NAME: _____ AGE: _____ BIRTHDATE: ____/____/_____ SEX:_____

SS#:_____ MARITAL STATUS: **SINGLE** **MARRIED** **DIVORCED** **WIDOWED** **SEPARATED**

ADDRESS: _____ CITY: _____ STATE:_____ZIP: _____

HOME PHONE: (____)_____ CELL: (____)_____ WORK: (____)_____

EMAIL: _____ OCCUPATION: _____

SHOE SIZE: _____ SHOE STYLE: _____

EMERGENCY CONTACT NAME & PHONE _____ RELATION: _____

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

INSURANCE AND RESPONSIBLE PARTY INFORMATION:

Primary Insurance Name: _____ *Subscribers Name & Date of Birth:* _____

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

Full Name: _____ Date of Birth: _____ Relationship to the patient:_____

Billing Address:_____City: _____ State: _____ Zip: _____

Is this injury related to a worker's compensation claim or auto accident? **NO** **YES**

Contact phone #_____

Name of insurance company_____ Date of Injury: _____ Claim #:_____

Is this claim Open? Y or N **If Yes, a copy of the "open claim letter" will be requested.**

Your Pharmacy Name: _____City: _____

Pharmacy Crossroads: _____

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

Name of your Primary Care Physician: _____ Phone # _____ Fax #_____

Street address: _____

Are you diabetic? **YES** **NO** **If Yes, Physicians name & Contact information treating your Diabetes:**

Name:_____Phone # _____

OVERALL HEALTH: GOOD / FAIR / POOR **HEIGHT: _____** **WEIGHT: _____**

Please Circle below all that apply past and present (please specify below) :**

CONSTITUTIONAL Fever Weight Loss Lethargy None Other (Specify): _____	**GLAUCOMA** Cataracts Glasses Legally Blind None Other (Specify): _____	**EAR, NOSE & THROAT** Tinnitus Nasal Congestion Sore Throat/Difficulty Swallowing None Other (Specify): _____
RESPIRATORY **Emphysema** **Asthma** Abnormal Cough None Other (Specify): _____	**CARDIOVASCULAR** **High Cholesterol** **Heart Murmur/DVT** **High Blood Pressure** ****Heart Problems/Stroke** **Leg Cramps** Lower Extremity Pain or Swelling None Other (Specify): _____	**SKIN/OTHER** Itching/Lumps/Rash Dry Skin/Calluses/Swelling Fungal Nails Ingrown Toenails Open Lesions **Ulcers** **Gout** Tumors None Other (Specify): _____
NEUROLOGIC/OTHER **Varicose Veins** **Nervousness** **Epilepsy/Seizures** Dizziness Memory Loss/Weakness/Fainting None	**MUSCULOSKELETAL** Limited Range of Motion Pain (musculoskeletal) Limited Strength Foot Deformity None ****Arthritis (specify below)** ****Artifical Joints (specify below)** Other (Specify): _____	**GASTROINTESTINAL** Heartburn/Reflux Stomach Problems Diarrhea Nausea None Other (Specify): _____
GENITOURINARY ****Urine abnormalities** (specify below) On Hemodialysis Incontinence None Other (Specify): _____ ***Cancer (specify below)** Other (Specify): _____	**HEMATOLOGIC/ LYMPHATIC** Easy Bruising/**Anemia** Blood Thinners Lymph Node Enlargement Hyper or **Hypoglycemia** **Bleeding Tendencies** **Tuberculosis** **H.I.V Positive** ****Kidney or Liver Disease** ****Hepatitis (specify below)** Other (Specify): _____	**ENDOCRINE** Night Sweats **Thyroid Disease** **Diabetes** None **WOMEN** Are you currently pregnant? YES NO

What concerns do you have regarding your feet?

_____

_

If you are Diabetic :

Circle: Type I or Type II

Last A1C: _____ Last Blood Sugar: _____

Immunizations:

Influenza - Date: _____

Pneumonia - Date: _____

Social History:

Tobacco Use:	**Alcohol Use:**	**Drug Use**
Previous Smoker/Never Smoked	Never Alcohol Use	Illegal Drug Use
Chew Tobacco/Current Smoker	Social Alcohol Use	Previous Drug Abuse
Smoke Cigarettes	Heavy Alcohol Use	Current or Previous
E-Cigarettes/Vape	Previous Alcohol Use	Opioid Abuse
		Marijuana Use
		No Drug Use

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 Darvo Cipro Tetanus Anesthetics Antihistamines Keflex Other:_____

ARE YOU ALLERGIC TO LATEX PRODUCTS: YES NO

ARE YOU ON BLOOD THINNERS: YES NO

CURRENT MEDICATIONS: **Please List all prescription medications you are taking, include Dosage & 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 / ASSIGNMENT AND RELEASE/MEDICAL HISTORY

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, credit card payments will be subject to a 3% fee. 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. 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. Past due balances will be charged a late fee of $15, monthly if payments are missed. Neglected/past due accounts over 90 days will be transferred to a Collection Service, and you will be charged additional collection/attorney fees. Payment arrangements can not be made if your account has been transferred to the collection service.

Do I need a referral or per-certification?

If your insurance plan requires a referral auth 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.. 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 for you. It is your responsibility to know what services your 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 canceled/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 number, 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 understand the medical information I have completed is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I have read, understand and received a copy of Patient Specialist Partnership Agreement. 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, copay's, 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: _____

PATIENT'S COPY TO KEEP

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/ACO (patients take an active role in their health care, working closely with both their PCP & Specialist , and Medicare Insurance). We work with your Primary Care doctor/Ins 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. Mon-Friday the office is closed for Lunch between 12:45-1:45.

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/urgent care and contact our office for follow up the next business day. Should you have an AFTER Hours issue please contact 586-779-6140, and we will direct you with the next steps.

Macomb Twp Urgent Care: Ascension Urgent Care 48200 23 Mile Rd & Romeo Plank, Macomb
Warren: Urgent Care Clinic 30736 Hoover, Warren
St Clair Shores: 25515 Harper Ave, St Clair Shores

Need Help? FINDHELP.ORG - Non profit agencies in your area that can help with Human, health and social needs (i.e., utilities, housing, health insurance food, diapers, etc.) visit FINDHELP.ORG

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

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INFORMATION / FINANCIAL RESPONSIBILITY

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OFFICE COPY

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

Information 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 V. 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

_____ Date: _____
Signature of Patient

_____ Date: _____
Signature of Parent or Legal Guardian

_____
Relationship to Patient