New Tampa Foot & Ankle

Dr. Stephen F. Levin, DPM, Dr. Martin Port, MS, DPM & Dr. Brendan Barrett, DPM
26827 Foggy Creek Road, Suite 104, Wesley Chapel, FL 33544
3704 Euclid Avenue, Tampa, FL 33629
Phone: 813-973-3535 | Fax: 813-907-2963

South Tampa Foot & Ankle

At both New Tampa Foot & Ankle AND South Tampa Foot & Ankle, we are committed to getting you back on your feet free of pain and injury so that you can get back to your activities and back into life! We understand that when your feet hurt, you hurt all over, and you stop doing the things you love to do. We stop the pain and prevent the injuries that occur in people's feet, ankles, legs, knees, hips and backs by addressing the imbalances in their bodies which most often begin in their feet! We feel your feet are your foundation and a strong foundation is our goal. We thank you for the opportunity to serve you and give you the results that you deserve.

Today's Date: ____/____/___

Patient Name: _____ Date of Birth: _____/_____/_____

If patient is under 18 y/o, name of Parent/Guardian: _____ Relationship to Patient: _____

Address: _____
(street) (city/state) (zip code)

Home Phone: (_____) _____-_____ Cell or Alternate Phone: (_____) _____-_____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Student □ Minor
Race: □ African American □ Asian □ Caucasian □ Hispanic □ Other:_____
Language: _____

**Email Address:** _____

Patient's Social Security#: _____ Driver's License #:_____

Primary Insurance: _____ I.D.#: _____ Group #: _____

Medicare #: _____

Secondary Insurance: _____ I.D. #: _____ Group #: _____

Employer: _____ Occupation: _____

Employer Address; _____ Phone: (_____) _____-_____

Spouse's name: _____ Spouse's Occupation: _____

Spouse's Employer: _____ Spouse's Work Phone: (_____) _____-_____

*Primary Insured's Name: _____

*Primary Insured's Date of Birth: _____ *Primary Insured's Social Security #: _____-_____-_____

***Primary Insured refers to the primary policyholder on the insurance plan.***

How did you hear about us? _____

In case of an emergency, notify: _____ Relationship: _____

Home Phone: (_____) _____-_____ Business Phone: (_____) _____-_____

**Okay to leave messages (appointment reminders, diagnostic results, etc) on machines? □ Yes □ No**
**Preferred method of contact: □ Email □ Cell Phone □ Home Phone □ Other _____**

*I authorize release of information necessary to process all insurance claims for services rendered and that any payment be made directly to the doctor. I understand that, regardless of my insurance, I am ultimately responsible for my account for any professional services rendered. Payment is due at the time of visit.*

_____ _____
Patient's, Parent's or Guardian's Signature Date

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Patient Name: _____ Date of Birth: _____ Date: _____
Primary Care Doctor: _____ Last visit: _____
Former Podiatrist Name: _____ Last visit: _____
Other Provider: _____ Last visit: _____

## MEDICAL HISTORY

□ Male □ Female Height_____ Weight_____ Shoe Size_____

1. What is your primary reason for visiting our offices: _____
2. How is your general health? □ Good □ Fair □ Poor
3. Are you now, or within the past two years, under a physician's care? □ Yes □ No
If yes, what are you being treated for: _____
4. Do you take prescribed and/or over the counter medicine? □ Yes □ No
If yes, what medications are you taking? (Please list or provide a copy of list): _____
5. Are you allergic to any medicines, adhesive tape, latex or penicillin? □ Yes □ No
(Please list ALL allergies you have): _____

6. Do you have now, or have you ever had any of the following:

□ Anemia
□ Arthritis
□ Asthma
□ Blood Diseases
□ Broken Bones in Legs or feet
□ Cancer – Type: _____
□ High Cholesterol/Triglycerides
□ Circulation Disease/Problems
□ Cramps in Feet or Legs
□ Diabetes
□ Digestive Problems
□ Epilepsy
□ Eye Problems
□ Gout
□ Heart Problems
□ Hepatitis
□ High Blood Pressure
□ HIV / AIDS
□ Kidney Problems
□ Liver Problems
□ Melanoma
□ Numbness of Feet / Legs
□ Phlebitis
□ Prolonged Bleeding
□ Raynaud's Disease
□ Rheumatic Fever
□ Skin Cancer
□ Stomach Ulcers
□ Thyroid Condition
□ Tuberculosis

7. If Diabetic, please check applicable: □Taking insulin □Taking medication(s) □Diet controlled
How long have you been diabetic?_____ What is your average blood glucose range? _____
When was your last A1C level drawn? _____ What was your last A1C number/value? _____

8. Is there a family history of diabetes? □ Yes □ No Which family member(s)? _____
Insulin Dependent? □ Yes □ No

9. Do you smoke? □ Yes □ No
If yes, how many packs per day? _____ How long have you smoked? _____
If you have quit smoking, how long ago did you stop? _____
How many packs per day did you smoke? _____ How long did you smoke? _____

10. Do you drink alcohol (please circle one): □ Never □ Rarely □ Occasionally □ Moderately □ Daily

11. Have you had any surgeries? □ Yes □ No [If yes, Please list below:]

| **Date** | **Surgical Procedure** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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# Financial Agreement

Dear Patient,
Thank you for choosing New Tampa Foot & Ankle and South Tampa Foot & Ankle, Dr. Martin Port, MS, DPM, Dr. Brendan Barrett, DPM, and Dr. Stephen F. Levin, D.P.M., P.A. as your podiatric health care provider. We are committed to the success of your treatment, as well as, providing you the best possible podiatric care. Please understand that payment of your bill is considered a part of your treatment. All patients must complete our Patient Registration form, provide their insurance card, and provide their driver's license/state identification card before seeing doctors Levin, Port, and Barrett. The following is a statement of our Financial Agreement, which we require you read and sign prior to any treatment. FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. WE ACCEPT CASH, VISA, MASTERCARD, AMERICAN EXPRESS, and DISCOVER.

**Regarding Medicare**
We are a Medicare Provider; therefore, we do accept assignment on Medicare. When possible, your claim will be filed to Medicare and any supplemental insurance that routinely pays the doctor for his services. For those patients that have a supplemental that does not routinely pay the doctor, or if you do not have a supplemental policy, we will require 20% of the total bill to be paid at the time of service. If there is a remaining balance after your insurance pays, then a bill will be sent to you, for your payment of the final balance. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered medically necessary under the Medicare Program. Our staff recognizes this, and we will attempt to take the time to discuss these charges with you prior to a service if we know it will not be covered by Medicare.

**Regarding Private Insurances**
If you are a member of an insurance company that we are a participating provider with, as a courtesy to you, we will file the claim directly with the insurance company. The amount of benefits you are entitled to depends solely on what your specific insurance company and plan offers to its members. Some insurance plans cover as little as 30 percent (30%) and some cover as much as 100 percent (100%) of your medical care. You will be responsible for your co-pays, your deductibles, your co-insurance percentages, and services that are not covered under your specific contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered medically necessary under your insurance program. Our staff recognizes this, and we will attempt to take the time to discuss these charges with you prior to a service if we know that it will not be covered.
If you are a member of an insurance company that we are not participating with, we ask that you pay the full amount of the visit at the time of service. We will provide you with a copy of your bill or help fill out a claim form, so you can submit it to your insurance company.

**Miscellaneous Policies**
To better serve the needs of our patients, we have been forced to implement our current policy of a $35.00 charge for broken appointments. This means that you have scheduled an appointment and do not show up or call 24 hours in advance to cancel that appointment. Such notice would have opened that appointment time up for another patient. We understand that emergencies happen, and that 24 hours' notice is not always possible, but please call as soon as you realize that you will not be able to make the appointment. Thank you for your cooperation and understanding in this matter.

Minors **must** be accompanied by a parent or legal guardian, with the Minor Consent for Medical Treatment form filled out.
Returned checks are subject to a $25.00 processing fee.
There will be charged a fee of $35.00 for any appointment missed with less than 24 hours cancellation notice.

All accounts must be paid upon receipt of our bill. If after 60 days, the balance is not paid in full; your account will be sent to our collection agency for the balance, plus a fifty percent (50%) collection fee.

If you have any questions about the above information, we will be glad to answer your questions. I have read the Financial Agreement. I understand and agree to the Financial Agreement.

I, the undersigned, authorize payment of the medical and surgical benefits directly to Dr. Stephen F. Levin, D.P.M., P.A. and to release information including the diagnosis and the records of any such medical or surgical care. I am also giving Dr. Stephen F. Levin, D.P.M., P.A., (including, Dr. Martin Port, MS, DPM, Dr. Brendan Barrett, DPM, New Tampa Foot & Ankle and South Tampa Foot & Ankle) all rights to inquire on my behalf on any medical reviews relating to my medical benefits, either assigned or non-assigned.

_____ _____
Signature of Patient/Responsible Party Date

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# Financial Addendum & Return Policy

Payment is due in full at the time of treatment unless prior arrangements have been made.
Our office accepts **NO** responsibility for your insurance benefits. ***Filing your benefits is a COURTESY that we provide.*** We will do everything that we can to help you get your full insurance benefit, but we will not guarantee what your insurance plan will pay.

Again, we do our best by calling your insurance company and verifying your coverage prior to your initial appointment; however, that information is not guaranteed to be current and accurate. We can only follow what we are told by your insurance provider. We may be verbally given a benefit or coverage amount during pre- qualification, only to have that claim denied when sent after treatment has been rendered. As a courtesy to you, the patient, we will seek clarification and re-file denied claims a second time. If such claim is denied a second time, we will then send a bill to you. This bill must be paid within 60 days of the billing date. You may, then attempt to obtain reimbursement from your insurance provider, and we will be happy to provide you with whatever receipts or Explanation of Benefits that you need.

Please know that we are told by insurance companies that **"payment is ultimately the patient's responsibility."** We have no control over the insurance provider or plan that we are presented with.
I, the patient or responsible party, understand that I am responsible for payment of services rendered and for paying co-payments, deductible, and co-insurances that my primary and/or secondary insurances does not cover. **I understand that all payment is ultimately my responsibility.**

## Return Policy for DME and Retail Items

Durable Medical Equipment (DME) such as custom total contact orthotics, walker boots, night splints or any type of ankle support devices are **non-refundable**.

We collect the following **deposits** for these DME items:

- Custom Orthotics: $450
  - $225 is due at the time of casting.
  - $225 is due at pick up - if your insurance company has either denied the service, or has not paid.
- Walker Boots: $150
- Night Splints: $150
- Other: _____

As always, we will bill the item(s) to your insurance; however, you are ultimately responsible for payment should your insurance company deny the claim or take the item towards you deductible or coinsurance. Please be advised, that even though we bill the item to your insurance, you may still owe a balance as we only collect a deposit. If a balance is owed, it is due upon receipt of the statement or at your next appointment. Note that accounts must be paid in full by your follow-up appointment. For some BCBS patients, we have noticed that they do not cover Orthotics. You may have to pay the self-pay rate and submit a claim to be reimbursed. Please see the 2017 Florida Blue Orthotic Notice form for more information.

**Please Note:** Starting on August 1st, 2017, New Tampa Foot and Ankle will no longer bill custom orthotics; code L3000 to Florida Blue – Blue Cross Blue Shield. The insurance company has notified us they are only covering custom orthotics for diabetic patients.

**Retail Payment Policy:**

All retail items are considered out of pocket and we **cannot** bill them to the insurance company. **All sales are final and non-refundable.**

All **second pair of orthotics and refurbishment of orthotics** are considered retail products and are not billed to the insurance company. All sales are final and non-refundable.

*By signing this agreement, you verify that you have read and understood the Return and Payment Policy.*

_____ _____
Signature of Patient/Responsible Party Date

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**PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS**

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:
(Print Patient Name)

I acknowledge that I was provided a copy of the Notice of Privacy Practices and I have read them or declined this opportunity to read them and understand the Notice of Privacy Practices.

The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

I understand that I have the right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restriction that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already acted in reliance on this Consent.

I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me. I understand that if I do not sign this Consent evidencing my Consent to the uses and disclosures described to me above contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the forgoing notice, and all my questions have been answered to my full satisfaction in a way that I can understand.

| | |
|---|---|
| _____ | _____ |
| Name of Individual (Printed) | Name of Legal Representative and Relationship |
| _____ | _____ |
| Signature of Individual | Signature of Legal Representative |
| Date Signed: ____/____/_____ | Witness: _____ |

Please list below any person that you <u>authorize</u> our office to communicate with on your behalf to discuss aspects of your care such as diagnostic and lab results.

| Printed Name | Date of Birth | Relationship | Address |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| Printed Name | Date of Birth | Relationship | Address |