Christopher J. Calcagni D.P.M. P.A. at Coastal Foot & Ankle Center
Phone: (239) 596 7024
Fax: (855) 700 2581

PATIENT REGISTRATION FORM

****Every page must have a signature**

Acceptable Identification is the following: driver license, passport, government ID, Military ID. ***You will <u>not</u> be seen without proof of identification or completed forms and signatures.***

(Please fill out each item or put N/A)

Legal Name: _____

Mailing Address: _____(City/St/Zip)_____

◯ Male ◯Female / Date of Birth: ____/____/_____ Social Security #:_____

Home # _____Cell #_____Work #_____

Email Address: _____
(Your email is essential for patient/doctor communication, appt reminders, portal communication)

Marital Status: ◯ Minor ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

Insured's Name/Date of Birth (*if different from above*): _____DOB:_____

Emergency Contact Name: _____Phone #: _____

Pharmacy/Address/Phone #: _____

Personal Physicians Name: _____

Physicians Address / Phone #: _____

I hereby give permission to Christopher J. Calcagni D.P.M. P. A. at Coastal Foot & Ankle Center and/or his associates to administer treatment and to perform such procedures,tests, labs as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. I also hereby assign to the above named physician, and associate all benefits provided by my insurance company policy or policies for my medical or surgical care. **I understand that I am financially responsible for any balance due on my account and a collection agency will be employed to enforce such.** Furthermore, **I have read and signed the financial responsibility form and understand the financial policy of Christopher J. Calcagni D.P.M. P. A. at Coastal Foot & Ankle Center This is a lifetime signature.**

As our physician and staff are fluent in English, it is the responsibility of the patient to provide an interpreter over the age of 18 if the patient will be unable to speak with and understand the physician. This is necessary for us to render medical care and for the protection of the patient.

Privacy and Information Protection Policy

Our office utilizes a HIPAA compliant Electronic Medical Record Storage system. All data collected on this form is strictly used for insurance claim purposes and never shared with outside sources. All information not stored in the electronic storage format is shredded and disposed of properly. **By signing below, you are acknowledging that you have either received a copy of our Privacy Policy or have been given access to a copy to review.**

It is understood that all Durable Medical Equipment & products including, but not limited to, creams, lotions, orthotics, arch supports, braces, pads, diabetic shoes,surgical shoes, can be purchased via an outside professional vendor. The products and in-office dispensing are for our patients' convenience; financial responsibility will be solely on the patient. All payments for such services or devices are due upon the receipt of service or item unless other arrangements have been made in advance.

Signature of Responsible Party:_____**Date:**_____

FINANCIAL POLICY

Please Realize:

1. We would like you to understand that your insurance policy is a contract that exists between yourself and your insurance company.Christopher J. Calcagni D.P.M. P.A. at Coastal Foot & Ankle Center relationship is with you as the patient, NOT your insurance. New insurance companies are forming and existing insurance companies are rapidly changing. It is YOUR responsibility to know the specifics of your policy (referral requirements, in/out of network physicians & facilities, etc.). Costs can vary depending on your specific insurance coverage and the particular treatment you receive. Our staff cannot guarantee eligibility, benefits or any cost/payment, if you have any questions or unsure about coverage, it is your responsibility to call and confirm with your insurance. We also rely on you to update us with any insurance and/or address changes.
2. **Medicare Patients**: We would like you to understand that taking assignment means that YOU are responsible for the yearly deductible determined by Medicare and for the 20% (coinsurance) of what Medicare allows. You are also responsible for the services that your coinsurance does not cover. We may ask you to sign a **Medicare Advance Beneficiary Notice (ABN)**, which states that if Medicare does not cover a service or medical equipment, you understand that you will be responsible for payment.
3. The filing of **SECONDARY INSURANCE CLAIMS** is a COURTESY that we extend to our patients. We will make every effort to help you in the filing of your claims; however, all charges are ultimately YOUR responsibility after the initial filing with your insurance company. We realize that temporary financial problems may affect timely payment on your account. We encourage you to contact us *promptly* for assistance in the management of your account.
4. I agree that if **my account falls delinquent**, I will be responsible for all collection costs, including but not limited to the outstanding balance, attorney fees, court costs, collection agency fees and interest from the date of service at the rate of 1.5% per month (18% annum).
5. I authorize ChristopherJ. Calcagni D.P.M. P.A. at Coastal Foot & Ankle Center to submit all insurance claims on my behalf. I understand that I am responsible for all services paid in full within 60 days of service, regardless of the reason given by the insurance company.
   ****There is a $25.00 charge to the patient for the completion of forms (insurance, disability, etc.).**
   ****Medical Record Fees are $1.00 per page for the first 25 pages and 25 cents for each additional page.**
   ****There is a potential $50.00 charge for patients who have an appointment and "no call/no show" two times.**
   ****We have a 10 minute late policy, if you show up more than 10 minutes late, we will gladly see you at a later time or day.**

PLEASE SIGN APPROPRIATELY BELOW

A) NON_PARTICIPATING AND SELF PAY STATUS - SIGN BELOW

We are not participating with every insurance company available. If you are not sure if we are participating, we encourage you to call your insurance company to verify our participation. **Ultimately, it is your responsibility to know your policy**. You will be responsible for full payment the day of your service

Signature: _____Date:_____

B) PARTICIPATING INSURANCES AND MEDICARE ASSIGNMENT - SIGN BELOW

I authorize payment of MEDICAL BENEFITS be made on my behalf to Christopher J. Calcagni D.P.M. P.A. at Coastal Foot & Ankle Center to the health care financing administration and its agents in order to process my claims. I understand ultimately I am responsible for all payments not rendered by my insurance.

Signature: _____Date:_____

Card on File Agreement Policy

Do I have to leave my card information on file to be a patient with Christopher J. Calcagni D.P.M. P.A. at Coastal Foot & Ankle Center

Yes, this is our policy. Due to new insurance companies forming and existing insurance companies rapidly changing, in order to continue being an in-network provider with most insurance companies, Dr. Calcagni has made the decision to focus on becoming more efficient in our billing and collecting process.

When will money be taken from my account?

Insurance companies on average take between 2-6 weeks to process submitted claims. Your individual policy and agreement with your insurance will determine what you may owe, copay, coinsurance, and deductible will be taken into consideration. Once the insurance explanation of benefits (EOB) is received and posted to your account, you will receive an email and the amount owed will be retrieved 5 days after the email was sent.

What if there is a payment discrepancy or questions regarding a balance?

This policy in no way compromises your ability to dispute a charge or question your insurance company's explanation of benefits.

How do we safeguard your card information on file?

We use the same methods to guard your card information as we do for your medical information. Your card information is securely protected by our HIPAA compliant practice management system. Our system will only allow Christopher J. Calcagni D.P.M. P.A. at Coastal Foot & Ankle Center staff to see the last four digits of your card, giving us no way to use your card outside of the billing system.

I hereby authorize Christopher J. Calcagni D.P.M. P.A. at Coastal Foot and Ankle Center to store my signature and card information securely on file and to charge my card for any outstanding balance when due.

If the card that I provide today changes, expires, or is declined for any reason, I agree to promptly provide Christopher J. Calcagni D.P.M. P.A. at Coastal Foot & Ankle Center with an updated valid card of which I will allow them to use for payment processing. I agree that my updated card may be used with the same authorization as the original card presented.

Card Holders Signature: _____ Date: _____

Email *(please print in your neatest handwriting)*: _____

PROTECTED HEALTH INFORMATION FORM (HIPAA)

AUTHORIZATION TO SHARE "PROTECTED HEALTH INFORMATION"

PURPOSE: To permit Christopher J. Calcagni D.P.M. P.A. at Coastal Foot & Ankle Center to share personal health information with persons other than the patient's name below:
Section I (Please print)

Patient Name:_____Date of Birth:____/____/_____

Section II: Identify the person(s) with whom your information may be shared and their relationship with you. Please Print. If none, write NONE

Name:	Relationship:	Phone #:	Access:
			○Billing ○Full Access
			○Billing ○Full Access
			○Billing ○Full Access

Section III: This authorization will expire only upon receiving written notification from me.

Acknowledgement: I, hereby, permit Christopher J. Calcagni D.P.M. P.A. at Coastal Foot & Ankle Center to share the following "protected health information" concerning me:

- Health Information concerning appointments; all past, present and future health information.
- All laboratory results and other diagnostic results (e.g., x-ray, pathology, MRI, etc.).
- Confirmation of appointment details
- Billing related inquiries

I understand that my "protected health information" may be shared with the people listed and they may not be required to comply with federal health information privacy laws. I understand that the practice reserves the right to deny access. In addition, authorized individual(s) must present Identification as proof that they are who they claim to be.

_____ _____/_____/_____

Signature Date

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida Law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care with Christopher J. Calcagni D.P.M. P.A. at Coastal Foot & Ankle Center it may be medically necessary to obtain a tissue or biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of your genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party disposal in accordance with all local, state, and federal requirements.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Christopher J. Calcagni D.P.M. P.A at Coastal Foot & Ankle Center to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____

Printed Name of Patient

_____

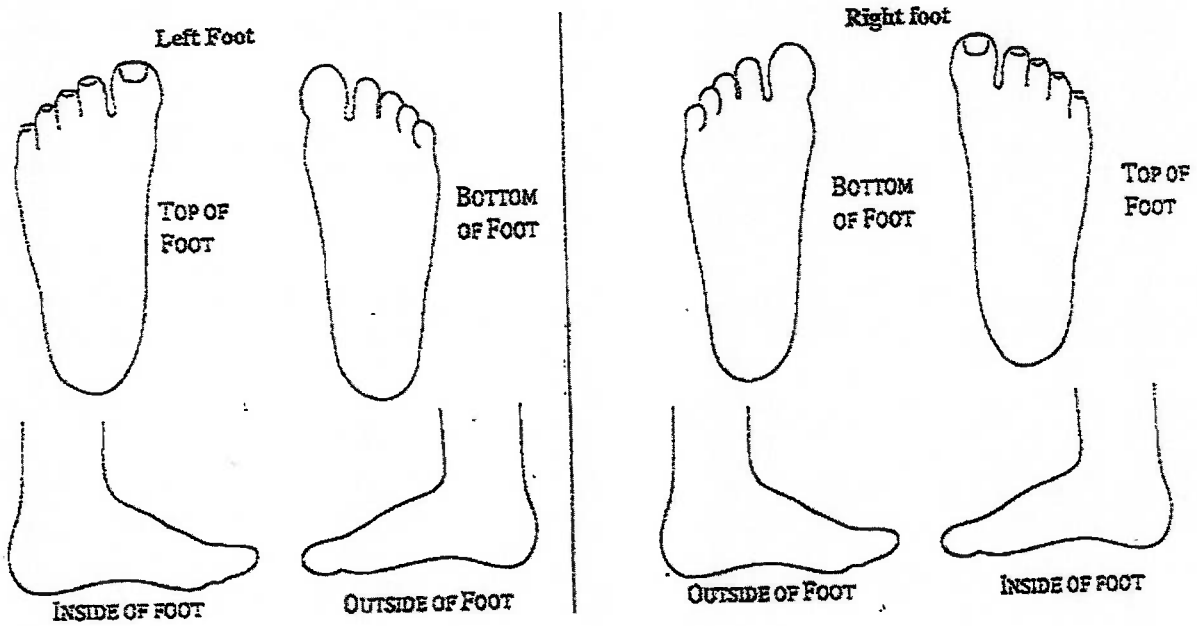
Signature of Patient

_____

Date

What specific problem brings you into our office today? _____

Where is the pain/problem located? Please mark on the picture's below



How long ago did this problem first start? _____ Days/ Weeks/ Months/ Years

Did your pain or problem: ◯ Begin all of the sudden ◯ Gradually develop over time

How would you describe your pain: ◯ No pain ◯ Sharp ◯ Dull ◯ Aching?

◯ Burning ◯ Radiating ◯ Itching ◯ Stabbing ◯ Other _____

How would you rate your pain on a scale of 0 to 10? (please circle)

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

Since the time your pain or problem began, has it:

◯ Stayed the same ◯ Gotten worse ◯ Improved

What treatments have you had for this problem?:_____

How tall are you:_____ Feet_____ Inches_____ Weight:_____ Pounds

Primary Care Physician: _____

- Is the condition a result of an injury? Yes, No If Yes, is this work related? Yes, No

Are you a diabetic? Yes, No If Yes, name of physician monitoring diabetes_____

Controlled by **Diet** **Oral Medication Insulin** **Last blood sugar:**_____

- Current Medications & Dosage _____ _____
  _____ _____
- Allergies & Reactions: _____
  _____
  _____
  _____
- Prior Surgeries: _____ when _____
  _____ when _____
  _____ when _____

Social History:

Tobacco? Yes, No Ifyes,How long? _____

Former Tobacco Users: How long ago did you quit? _____

Alcohol? Yes, No If yes, How often? _____

Do you use recreational drugs? Yes, No

Past Medical History

Circle any that apply to you

Diabetic	Back Problems	Parkinson's Disease	Other _____
Heart Disease	Bleeding Disorder	Hepatitis	_____
High Blood Pressure	Epilepsy	cancer	_____
stroke	Gout	Multiple Sclerosis	_____
Phlebitis (vein inflammation)	Tuberculosis	osteomyelitis	_____
Kidney Disease	High Cholesterol	Arthritis	_____
Respiratory Disease	Thyroid Problem	AIDS/HIV	_____
Alzheimer's Disease	Neuropathy		