John Eric DeCato, DPM Inc

3903 Lake Avenue
Ashtabula, OH 44004-5833
Phone (440) 992-4477 Fax (440) 998-5452

Policy for Credit Card on File

Please read the policy below and fill out all information.

In an attempt to better serve you and reduce costs that could be passed on to you, we have implemented a new policy. This new policy has gone into effect for the entire practice and your participation is required. Under our new policy, we will keep credit card information on file for all patients. This will be used to cover any charges not paid by insurance. Patients will still be expected to pay known co-pays, co-insurance, and applicable deductibles at the time of service. If a balance remains after insurance has paid, you will receive one statement for the services and after 30 days, any amount left on your account after insurance has been processed will be placed on your credit card. (It is the responsibility of the patient to contact our office if there is any question regarding the claim or amount due). The information you provide will be kept securely and will only be used for your medical expenses.

Your understanding and patience with this new policy is important. We are confident this new policy will make it easier for you to keep track of your medical expenses and will give you an opportunity to review the explanation of benefits your carrier sends to you, before you are charged. No charges will be placed on your card until after we hear from your insurance carrier, and if you choose to pay your balance in a different way, you may do so before the 30 days have elapsed.

Credit Card Type:

☐ *MasterCard* ☐ *Visa* ☐ *Discover* ☐ *American Express* ☐ *Care Credit*

Credit Card Number: ______________________ *Expiration Date:* ____________

Security Code (3-digit code on back of card): ____________

Carholder's Name (print): ______________________

Cardholder's Signature: ______________________ *Date:* ____________

Billing Address for card: (Street) ______________________

(City, Zip) ______________________

Credit card Consent Form

I authorize John Eric DeCato, DPM Inc to maintain my credit card information for payment if any balance not paid by my insurance as agreed above. I assign my insurance benefits to the provider listed above authorizing payment by my insurance company to John Eric DeCato, DPM Inc. I authorize John Eric DeCato, DPM Inc to apply the balance of my account to the credit card listed above to include co-pays, deductibles, and any balance that might remain after my insurance has been processed. I understand that this form is valid until I provide written notice that it is revoked (after all balances are paid in full.) I also understand that if I change charge cards, I will supply John Eric DeCato, DPM Inc the new credit card information

******Our office will not call any patient prior to applying charges to a credit card after a statement has been sent and 30 days have passed.***

Any contact regarding charges or disputes will be the responsibility of the patient.***

To be filled in by office below

Account Number: ______________________ Physician: ______________________

NEW FEDERAL REQUIREMENTS

STANDARDIZATION FOR HEALTH CARE QUALITY IMPROVEMENT

Our office is currently transitioning to the new Medical Records System and we are required to collect the following information:

RACE________________ ETHNICITY__________________ MAIN LANGUAGE _________________

- o I PREFER NOT TO REPORT THIS INFORMATION

The Agency for Health Care Research and Quality (AHRQ), the federal agency within HHS with overall responsibility for health care quality improvement, routinely links the collection of the above data to health care quality improvement.

PRIMARY CHOICE OF PHARMACY: _____________________ LOCATION: _____________________

PATIENT SIGNATURE: ____ DATE: _________________

John E. DeCato, D.P.M., Inc.

John E. DeCato, D.P.M.
Lori A. Herpen, D.P.M.
Douglas I. Vis, D.P.M.
Susan Orabovic, D.P.M.

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I have been informed of the Health Insurance Portability and Accountability Act (HIPPA) regarding medical records in this office.

____________ Date	____________ Patient Name
____________ Chart#	____________ Patient Signature

John E. DeCato, DPM, Inc.

3903 Lake Avenue ** Ashtabula, OH 44004 ** (440) 992-4477

PATIENT & INSURANCE INFORMATION

PATIENT:____
Last Name First Name Middle Initial

ADDRESS:____

CITY:________________ STATE:__________ ZIP CODE:__________

Home Phone______________ Work Phone______________ Cell Phone__________

Patient SS#__________________ Date of Birth__________ Age_____ Sex_____

Email Address____

Employer____________________ Address______________________________

Person Responsible for the bill________________ Relationship to Patient__________

Date of Birth__________ Complete address______________________________

SS#__________________Home phone #__________Work phone #__________

Policy holder (if different than responsible party)__________________________
Relationship to patient ____________________

Date of Birth__________ Complete address______________________________

SS#__________________ Home phone#__________ Work phone #__________

Emergency Contact Person________________________ Phone #__________

Relationship____________ Address______________________________

Spouse Name______________ SS#________________ Date of Birth__________

Spouses Employer__________________________

Who is your primary care
Physician?____________________Address______________________________

PRIMARY INS.____________

POLICY HOLDER____________
GROUP#__________
ID#______________
PHONE#______________

COPAY: YES / NO/ AMOUNT$________
(CIRCLE ONE)
REFERRAL: YES / NO/
(CIRCLE ONE)

SECONDARY INS.____________

POLICY HOLDER____________
GROUP #______________
ID #________________
PHONE # ______________

COPAY: YES/NO/ AMOUNT$______
(CIRCLE ONE)
REFERRAL: YES/NO
(CIRCLE ONE)

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. Please understand that payment of your bill is considered to be your responsibility. The following is a statement of our Financial Policy. All patients must complete a Medical history, Insurance form, and the Financial Policy.

WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD

INSURANCE:

We accept assignment of insurance benefits if we are a participating provider. It is your responsibility to inform our office of any changes with your health insurance. Your health coverage is a contract between you and your insurance company; we will not act as a third party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will become your responsibility. Please be aware some, perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other medical insurances.

INITIAL_______

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

INITIAL______

SELF-PAY PATIENTS:

Adult patients are responsible for **full payment** at time of service.

INITIAL______

MINOR PATIENTS:

ANY adult (parent or guardian) who accompanies a minor and completes the paperwork is responsible for any balance. We will not be involved in insurance/custody issues. For unaccompanied minors, non-emergency treatment will be denied.

INITIAL______

MISSED APPOINTMENTS:

It is our policy to charge a **$30.00 charge** for missed appointments, unless the appointment is cancelled at least 24 hours in advance. Please help us serve you better by keeping your appointments and arriving **prior** to your scheduled appointment time.

INITIAL______

COLLECTIONS:

For any account that is sent to collections, it is our policy to charge a **$15.00 collection fee** in addition to the outstanding balance. Please pay your balances in **full** and **on time**.

INITIAL_________

PATIENT SIGNATURE________________________________ DATE________

CO-RESPONSIBLE PARTY_____________________________DATE________

I authorize the release of any and all medical records and/or information in the possession or custody of Dr. John E. DeCato, DPM, Inc., including information regarding HIV, Aids, alcohol and/or chemical dependency or treatment, which records and/or information may be released to all federal and state agencies including, without limitation, Health Care Financing Administration, Social Security Administration, Bureau of Employment Services and Bureau of Workers' Compensation, and all private insurance companies and/or third party payors or their agents, and any other physicians, whether primary care or specialist, upon request of such medical records or information. I further permit a copy of this authorization to be used in place of the original. This authorization shall remain valid until revoked in writing by me.

I understand that I am financially responsible for all medical services rendered which are not paid for by public or private insurance programs or other third party payors, including without limitation, Bureau of Workers' Compensation.

Date_______________________

Patient Signature____

SIGNATURE ON FILE

I request that payment of my charges, or that of my family be sent directly to Dr. John E. DeCato, DPM, Inc. from my insurance carrier.

PATIENT SIGNATURE____________________________

PATIENT BEING SEEN____________________________

DATE_____________

MEDICARE INFORMATION FORM
MEDICARE PATIENTS ONLY

PHYSICIAN/SUPPLIER NOTICE: Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. Therefore, in your case, Medicare may or may not deny some of your medical treatment or medical equipment.

BENEFICIARY AGREEMENT: I have been notified by my physician that he believes that in my case, Medicare may deny payment for some medical services as stated above. If Medicare denies payment, I agree to be personally and fully responsible for payment.

PATIENT PRINTED NAME:___________________________

PATIENT SIGNATURE:______________________________

DATE:____________

Name of physician requesting this consultation?______________________________

If self referred, who recommended this practice?______________________________

CHIEF COMPLAINT:______________________________
REASON FOR VISIT?

HISTORY OF PRESENT ILLNESS:

LOCATION:______________________ WHERE IS THE PAIN/PROBLEM?

TYPE OF PAIN:__________________

SEVERITY:______________________

DURATION:______________________ WHEN DID THIS PAIN BEGIN?

TIMING:______________________ DOES PAIN OCCUR AT SPECIFIC TIMES?

CONTEXT:______________________ HOW DID THIS BEGIN?

ASSOCIATED SYMPTOMS:______________________

MODIFYING FACTORS:______________________ WHAT MAKES PROBLEM BETTER OR WORSE?

Is your problem related to an accident? YES or NO

Do you get frequent leg cramps or numbness in your feet or toes? YES or NO

PAST HISTORY

Diagnoses (What medical conditions does your primary Doctor treat?):______________________________

Date and Reason for Hospitalizations:______________________________

REVIEW OF SYSTEMS

Are you currently or have you had problems with the following: If so when?

Constitutional	**Circle one**
Fever	Yes No
Weight Loss	Yes No
Excessive Fatigue	Yes No
Night Sweats	Yes No

Eyes	**Date of last Exam:**________
Wear Glasses	Yes No
Infections	Yes No
Injuries	Yes No
Glaucoma	Yes No
Cataracts	Yes No

Ear, Nose, Throat and Mouth

Wear Hearing Aids	Yes No
Hearing Loss	Yes No
Ear Infections	Yes No
Balance Disturbances	Yes No
Nasal Congestion	Yes No

Date of Last Exam:______________

Ear Pain	Yes No
Ringing in Ears	Yes No
Nosebleeds	Yes No
Nasal Drainage	Yes No

Patient Name________________________ Date of Birth____________ Age____

Ear, Nose, Throat and Mouth (con't)

Inability to Smell Yes No
Sinus Headaches Yes No
Mouth Sores Yes No
Sinus Problems Yes No
Sore Throats Yes No

Cardiovascular

Chest Pain or Angina Yes No
High Blood Pressure Yes No
Heart Murmur Yes No
History of Heart Attack Yes No
Date of Last EKG:__________
Irregular Pulse Yes No
High Cholesterol Yes No
Leg Pain While Walking Yes No

Respiratory

Asthma Yes No
Emphysema Yes No
Bronchitis Yes No
Lung Cancer Yes No
Date of Last Chest X-Ray:______________
Chronic Cough Yes No
Shortness of Breath Yes No
Pneumonia Yes No
Bloody Sputum Yes No

Gastrointestinal

Nausea Yes No
Blood in your Vomit Yes No
Jaundice Yes No
Colitis Yes No
Colon Cancer Yes No
Vomiting Yes No
Liver Disease Yes No
Abdominal Pain Yes No
Ulcers or Gastritis Yes No
GERD Yes No

Genitourinary

Urinary Tract Infections Yes No
Blood in Urine Yes No
Incontinence Yes No
Kidney Stones Yes No
Endometriosis (females) Yes No
Painful Urination Yes No
Difficulty Starting or Stopping Stream Yes No
Prostate Cancer (males) Yes No
Uterine or Cervical Cancer (females) Yes No

Musculoskeletal

Broken Bones Yes No List:______________________________
Arm or Leg Weakness Yes No
Arm or Leg Pain Yes No
Osteoporosis Yes No
Back Pain Yes No
Joint Pain or Swelling Yes No
Osteopenia Yes No
Arthritis Yes No--------If Yes, Please Circle Rheumatoid or Osteoarthritis

Integumentary

Skin Disease Yes No
Skin Cancer Yes No
Nipple Discharge Yes No
Breast Pain, Tenderness, or Swelling Yes No
Date and Result of last Mammogram (females):______________________

Patient Name______________________________ **Date of Birth**____________ **Age**____

Neurological

Fainting Spells or "Blacking Out"	Yes No	Seizures	Yes No
Disorientation	Yes No	Memory Problems	Yes No
Inability to Concentrate	Yes No	Difficulty with Speech	Yes No
Face Weakness	Yes No	Double or Blurred Vision	Yes No
		History of Stroke or TIA	Yes No

Psychiatric

Anxiety Yes No Depression Yes No

Other Psychiatric Disorder/Treatment:______________________________

Endocrine

Diabetes	Yes No	Thyroid Disease	Yes No
Increased Appetite	Yes No	Excessive Thirst or Urination	Yes No
Hormone Problems	Yes No		

Hematologic/Lymphatic

Anemia	Yes No	Hemophilia	Yes No
Bleeding Tendencies	Yes No	Persistent Swollen Glands or Lymph Nodes	Yes No

Blood Transfusion Yes No----If Yes, Why?______________________________

Allergic/Immunologic Disorders

Food Allergies	Yes No	Inhalant (nasal) Allergies	Yes No
Immunologic Disorders	Yes No		

Are you at risk for Aids (e.g. sexual orientation, drug abuse, previous blood transfusion)?
No_____ Yes_____, please explain: ______________________________

Do you require antibiotics prior to surgery or dental work? Yes No

If you are a woman, are you pregnant? Yes No

Do you have a living will? Yes No

Do you have a advanced directive? Yes No

FAMILY MEMBER	ALIVE	DECEASED	AGE	MEDICAL DIAGNOSES OR CAUSE OF DEATH
MOTHER				
FATHER				
SISTER				
BROTHER				
GRANDFATHER(PATERNAL)				
GRANDMOTHER(PATERNAL)				
GRANDFATHER(MATERNAL)				
GRANDMOTHER(MATERNAL)				
OTHER-				
OTHER-				

Patient Name________________________ Date of Birth____________ Age____

SURGERIES	YEAR	COMPLICATIONS

Have you ever had problems with anesthesia? ____Yes ____No

ALLERGIES TO MEDICATION- Are you allergic to or had an adverse reaction to:

Penicillin or other Antibiotics Yes No * Tranquilizers or sleeping pills Yes No
Codeine or other pain med's Yes No * Aspirin Yes No
Other:____

CURRENT MEDICATIONS OTC & PRESCRIBED	DOSE	FREQUENCY

SOCIAL HISTORY

Occupation:______________________
Marital Status: Please Circle One----- Single * Married * Divorced * Widowed
Do you have children? Yes No How Many?__________
Do you live alone? Yes No Who lives with you?______________

Do you smoke? ___Yes, I've smoked___packs of cigarettes per day for _____years.
___Yes, I smoke cigars or a pipe.
___Yes, I use chewing tobacco or snuff.
___No, I have never smoked.
___No, I quit ___years ago. At that time I was smoking ___packs per day for ___years.
Do you drink alcohol? ___No, never (or rarely) ___No, but I used to
___Yes ___ Daily ___1 or more x's a week ___1 or more x's a month
Do you use recreational drugs? Yes No
How much caffeine do you consume in a day?______________________

Patient Signature__________________________ Date____________

I have reviewed the above information with the patient.

Physician Signature__________________________ Date____________

PATIENT RESPONSIBILITIES

1. Follow all office rules and regulations.
2. Be responsible for your own personal items.
3. Provide to the best of his/her knowledge, accurate And complete information about matters relating to his/her health
4. Be considerate and respectful to other patients, office personnel, office property, and the property of others.
5. Providing all needed information for insurance processing and for assuring the financial obligations of his/her care.
6. Following the treatment plan.
7. Asking questions when he/she does not understand information or instructions.
8. Responsibility for one's actions when he/she refuses treatment or fails to follow treatment plan.
9. To report perceived risks and/or unexpected change in condition during the course of his/her care and side effects.
10. Reporting episodes of pain and lack of response to pain treatment.

PATIENT COPY