

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 two statements for the services and after 60 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 60 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): _____

Cardholder'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.

*****If your account should go into collections our office will not call any patient prior to applying charges to a credit card after a statement has been sent and 60 days have passed. Your receipt will be your bank statement.**

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

PATIENT SIGNATURE: _____ **ACCOUNT NUMBER:** _____

TO BE FILLED OUT BY OFFICE



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

John E. DeCato, D.P.M.
Lori A. Herpen, D.P.M.
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<http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf>

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

DATE: _____ PATIENT NAME: _____

CHART NUMBER: _____ PATIENT SIGNATURE: _____

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 _____

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, 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. _____ SECONDARY INS. _____

POLICY HOLDER _____	POLICY HOLDER _____
GROUP# _____	GROUP # _____
ID# _____	ID # _____
PHONE# _____	PHONE # _____

COPAY: YES / NO/ AMOUNT\$ _____ (CIRCLE ONE)

REFERRAL: YES / NO/ (CIRCLE ONE)

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

Eyes

Date of last Exam: _____

Fever Yes No
Weight Loss Yes No
Excessive Fatigue Yes No
Night Sweats Yes No

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 Problems	Yes No
Sinus Headaches	Yes No	Sore Throats	Yes No
Mouth Sores	Yes No		

Cardiovascular

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

Respiratory

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

Gastrointestinal

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

Genitourinary

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

Musculoskeletal

Broken Bones	Yes No	List: _____	
Arm or Leg Weakness	Yes No	Back Pain	Yes No
Arm or Leg Pain	Yes No	Joint Pain or Swelling	Yes No
Osteoporosis	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
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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 the 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 refused treatment or fail 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