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.
Douglas I. Vis, D.P.M.
Susan Orabovic, 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: _____ LOCAL: _____

PRIMARY CHOICE OF PHARMACY: _____ MAIL ORDER: _____

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._____

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:_____ **TYPE OF PAIN**:_____
WHERE IS THE PAIN/PROBLEM?

SEVERITY:_____ **DURATION**:_____
WHEN DID THIS PAIN BEGIN?

TIMING:_____ **CONTEXT**:_____
DOES PAIN OCCUR AT SPECIFIC TIMES? 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	Wear Glasses	Yes No
Weight Loss	Yes No	Infections	Yes No
Excessive Fatigue	Yes No	Injuries	Yes No
Night Sweats	Yes No	Glaucoma	Yes No
		Cataracts	Yes No

Ear, Nose, Throat and Mouth

Wear Hearing Aids	Yes No	Date of Last Exam:_____	
Hearing Loss	Yes No	Ear Pain	Yes No
Ear Infections	Yes No	Ringing in Ears	Yes No
Balance Disturbances	Yes No	Nosebleeds	Yes No
Nasal Congestion	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
		Memory Problems	Yes No
Disorientation	Yes No	Difficulty with Speech	Yes No
Inability to Concentrate	Yes No	Double or Blurred Vision	Yes No
Face Weakness	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:_____

PRIMARY LOCAL PHARMACY: _____ LOCATION_____

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 pan.

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.

11. No cell phone use or picture taking while in exam rooms.

Patient signature_____ Date_____

Please sign acknowledging that you have read and understand the patient responsibilities

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PATIENTS COPY