FRED LOMBARDO, DPM

DATE ____________________________

PATIENT NAME____AGE_________________

ADDRESS____________________________________CITY____________________ST_____ZIP___________

HOME PHONE___________________CELL PHONE__________________WORK PHONE__________________

EMAIL ADDRESS____

BIRTH DATE_________________MALE____FEMALE____SOCIAL SECURITY NO________________________

ETHNICITY_________________PREFERRED LANGUAGE_____________________RACE__________________

SPOUSES NAME________________________________

REFERRED BY____

EMPLOYER____

EMERGENCY CONTACT____RELATIONSHIP_______________

ADDRESS____PHONE_________________________

PHARMACY_________________________________CITY_______________PH NO______________________

PRIMARY CARE PHYSICIAN_______________________________________PH NO_____________________

MEDICATIONS____

ALLERGIES____SURGERIES______________________________

FAMILY HISTORY PLEASE CIRCLE: MOTHER: HEART DISEASE / DIABETES

FATHER: HEART DISEASE / DIABETES

DO YOU SMOKE? YES______ NO_______ AMOUNT DAILY ________ FORMER SMOKER _______

DIABETIC: YES____NO_____

FLU SHOT: YES/NO: DATE______PNEUMONIA: YES/NO: DATE______SHINGLES: YES/NO: DATE______

HEIGHT_____________WEIGHT_____________SHOE SIZE_________BLOOD PRESSURE______/______

HISTORY OF PHYSICAL OR MENTAL ABUSE: YES____NO____

MEDICAL CONDITIONS: (PLEASE CIRCLE) DIABETES GOUT ARTHRITIS HYPERTENSION HEART DISEASE CANCER ASTHMA BRONCHITIS EPILEPSY GALL BLADDER HEPATITS KIDNEY DISEASE LUNG DISEASE PNEUMONIA RHEUMATIC FEVER TUBERCULOSIS OTHER______________________________

REASON FOR TODAY'S VIST_______________________________________RIGHT____LEFT____BOTH_____

FRED LOMBARDO, DPM DATE____________________

PATENT NAME: ____

INSURANCE INFORMATION: REFERRAL NEEDED: YES____NO_____ COPAY AMOUNT______________

INSURANCE NAME______________________________POLICY NO______________________________

SUBSCRIBER NAME_________________________RELATIONSHIP__________BIRTH DATE____________

DEDUCTIBLE AMOUNT_________HRA: YES___NO___ HSA: YES___NO___ FLEX SPENDING: YES___NO__

WORKMANS' COMPENSATION INJURY: YES___NO___ DATE OF INJURY:________________

AUTHORIZATION TO LEAVE MESSAGE: I HEREBY AUTHORIZE FRED LOMBARDO, DPM TO LEAVE A MESSAGE FOR PENDING APPOINTMENTS AND/OR TESTS AT MY RESIDENCE FOR MYSELF AND/OR MY MINOR CHILD. YOU MAY NOTIFY ME OF LAB/TEST RESULTS, MATTER RELATING TO PRESCRIPTIONS, MY PHYSICIAN AND FRED LOMBARDO, DPM.

_____HOME ANSWERING MACHINE/VOICEMAIL ________MOBILE PHONE

_____SPOUSE/PARTNER ________EMAIL ACCOUNT

_____FAMILY MEMBER PLEASE SPECIFY NAME___________________________

***PATIENTS UNDER AGE OF 18 MUST BE ACCOMPANIED BY PARENT OF LEGAL GUARDIAN.

I hereby authorize payment of medical benefits to Fred Lombardo, DPM. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all of the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

SIGNATURE____DATE____________________________

PLEASE PRESENT YOUR INSURANCE CARD AND VALID DRIVERS LICENSE OR PHOTO ID

INSURANCE CO-PAYMENTS ARE DUE AT THE TIME OF THE VISIT

THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATIONABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY

Our commitment here at Fred Lombardo, DPM is to serve our patients with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests, it may be necessary to share information with other healthcare providers or business associates. The following are examples of instances where information may be shared: Laboratory analysis; billing and/or collection service; second opinions.

AMENDMENTS/APPOINTMENTS

We reserve the right to change our Notice of Privacy Practice and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of change. You may obtain a revised notice by contacting the Privacy Officer at: 576 Wyoming Ave., Kingston PA 18704, 570-283-5525. **Patients MUST contact the office 24 hours prior to cancelling an appointment. Missed appointments without 24 hour notice will incur a $50 missed appointment fee.**

INSURANCE BILLING PRACTICES

If we are a participating provider, we will forward claims to your insurance company. It is the responsibility of the patient to determine if we are in network with your insurance company and to obtain a referral if required. You **MUST** have the referral with you or have sent to our office at the time services are rendered. The patient is responsible for all copays, deductibles, coinsurances and non-covered services.

ROUTINE FOOT CARE APPTS: You must inform this office if you have seen another podiatrist with the previous 61 days. Any insurance claim denied due to frequency or factors beyond our control will become the sole responsibility of the patient.

ACKNOWLEDGEMENT AND CONSENT

We are committed to obeying all federal, state and local laws and regulations regarding privacy practices. If any other uses or disclosures other than the ones listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided for by law, may revoke this written authorization at any time.

I have read and understand the above Notice of Privacy Practices.

Signed:____Date:____________________________
(Patient, Parent or Legal Guardian)

Name(s) of those to whom you may release my medical information:

____

Assignment of Benefits

Fred Lombardo, DPM
576 Wyoming Avenue
Kingston, PA 18704
570 283-5525

Patient: ___________________________

I, ____________________________, understand that services rendered to me by Fred Lombardo, DPM are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Fred Lombardo, DPM and I understand that I will be fully responsible for any outstanding balance on my account. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my copay and coinsurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of said claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Fred Lombardo, DPM within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collection process, I will be responsible for any cost incurred by the office to retrieve their monies.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Fred Lombardo, DPM to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Date: __________________________________ Witness: ______________________________________

Signature of Patient or Guardian: ____