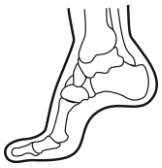

Dr. Will A. Rosena, DPM

Podiatric Surgeon

Saving Limbs – Enhancing Lives

NEW PATIENT PACKET – **PATIENT INFORMATION FORM**

Patient Name: _____ ❒ Patient is a Minor Date: _____
(First) (Middle) (Last)

Date of Birth: _____ Gender: ❒ M ❒ F Marital Status: ❒ S ❒ M ❒ W ❒ D SS# _____

Address: _____
(Street) (City) (State) (Zip + 4)

Phone: _____ Cell: _____ E-Mail: _____

Primary Care Physician: _____ **Date of Last Visit**:_____ Date of Birth:_____

Employer: _____ Emergency Contact:_____ Phone: _____

Required by Medicare Ethnicity: ❒ Not Hispanic or Latino ❒ Hispanic or Latino
Race: ❒ White ❒ Black ❒ Asian ❒ American Indian or Alaska Native ❒ Hawaiian or Pacific Islander

Primary Insurance: _____ I.D. # _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder's SS#: _____ Relationship to Patient: _____

Secondary Insurance: _____ I.D. # _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder's SS#: _____ Relationship to Patient: _____

Permission to Contact Patient at Home

❒ I give permission to Dr. Will A. Rosena, DPM/staff to call me at home.
❒ I give permission to Dr. Will A. Rosena, DPM/staff to leave a voicemail at _____(tel.#).
I give permission to Dr. Will A. Rosena, DPM/staff to leave a message with: ❒ anyone answering the phone, OR
❒ with the following members of my household _____.
❒ I give permission to Dr. Will A. Rosena, DPM/staff to email me with appointment reminders or anything pertaining to my health.

How did you hear about us? Doctor Referral (name) _____ Friend/Family _____
❒ Hospital (ER) ❒ Website ❒ Phone book ❒ Sign ❒ Previous Patient ❒ Other _____

Credit Card Information and Authorization

By providing my credit card information here, I am authorizing staff of Dr. Will A. Rosena, DPM to bill my credit card for any unpaid balances owing.

Name on Card: _____ Credit Card #: _____ Expiry Date: _____

Type of Card: ❒ MasterCard ❒ VISA ❒ Discover ❒ Debit Signature: _____

I attest that the information provided on this form is complete and accurate to the best of my knowledge. I hereby authorize Dr. Will A. Rosena, DPM to furnish any medical/demographic information necessary to process insurance claims for my treatment acquired in the course of the examination or hospitalization. I authorize payment of medical/surgical benefits to Dr. Will A. Rosena, DPM. I understand that the provider's charge may exceed the insurance allowed amount and payment. I will be responsible for all balances such as co-insurance, co-payments, and deductibles.

_____ _____
Signature of Patient/Legal Guardian Date

_____
Print Name

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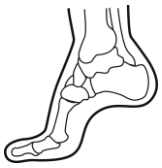

Dr. Will A. Rosena, DPM

Podiatric Surgeon

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NEW PATIENT PACKET – **MEDICAL HISTORY FORM**

Name: _____ Date:_____

Birthdate: _____ Age: _____ Height: _____ Weight: _____

Occupation/Employer _____

Pharmacy _____ Pharmacy Tel.# & Zip Code_____

Primary Care Physician: _____ **Date of Last Visit**: _____

Do you have Diabetes? ❒ Y ❒ N **Do you wear Diabetic shoes?** ❒ Y ❒ N **Date Last Pair Shoes Received**:_____

Doctor Managing Diabetes: _____ **Date of Last Visit**: _____

What is the Main Reason you need to see the Podiatrist? _____

When did your problem first begin? #____ Days ago #____ Weeks ago #____ Months ago #____ Years ago

Was it related to an injury? ❒ Yes ❒ No If Yes, What Type?_____

Which activities make your condition worse? (Please check all that apply)

❒ Standing up from a seated position ❒ Walking ❒ Running ❒ Uneven ground ❒ Certain Shoes ❒ Athletics ❒ Work

❒ Exercise ❒ Lifting ❒ Walking Barefoot ❒ Other: _____

Which Treatments have you tried? ❒ Anti-inflammatory medication ❒ Physical Therapy ❒ Stretching ❒ Surgery

❒ Shoe Modifications ❒ Padding ❒ Inserts ❒ Bracing ❒ Cortisone injections ❒ Pain Medication ❒ Tylenol

❒ Aspirin ❒ Soaks ❒ Ice ❒ Heat ❒ Rest ❒ Topical medications ❒ Other: _____

Does anything make your condition better? ❒ No ❒ Yes If yes, Explain: _____

YOUR PAIN TODAY: On a scale of **zero** to **10**, HOW BAD IS YOUR PAIN _____? (zero = no pain; 10 = worst pain)

Has any other physician/person treated this condition? ❒ No ❒ Yes **What was the diagnosis**? _____

If Yes, who treated you and when? _____

Have you ever been to a podiatrist before? ❒ No ❒ Yes If Yes, who was Podiatrist? _____

Family History: (When asked WHO, indicate mother, father or sibling;)

❒ **Arthritis**: _____(type); _____(who); ❒ **High BP**: _____(who)

❒ **Cancer**: _____(type); _____(who); ❒ **Heart Disease**: _____(who)

❒ **Diabetes**: _____(who); ❒ **Other**:_____(who)

Mother Age:_____, ❒ Deceased; Father Age: _____, ❒ Deceased; Sibling Age:_____, ❒ Deceased; _____, ❒ Deceased

Social History: Do you Smoke? ❒ Yes ❒ No How many? _____ per day How long? _____ Quit when? _____

Do you drink Alcohol? ❒ Yes ❒ No How many per week? _____ Do you do illicit Drugs? ❒ Yes ❒ No Type:_____

Please List Past Surgeries & Hospitalizations: _____

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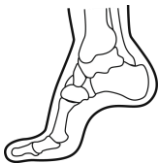

Dr. Will A. Rosena, DPM

Podiatric Surgeon

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PAST Medical History (Please check all the Conditions you had in the **PAST**)

- ❒ Acid Reflux/GERD
- ❒ Alzheimer's/Dementia
- ❒ Anemia
- ❒ Arthritis
- ❒ Asthma
- ❒ Cancer, Type: _____
- ❒ Chronic Back Pain
- ❒ Cirrhosis
- ❒ Congestive Heart Failure
- ❒ Depression
- ❒ Diabetes
- ❒ DVT (blood clot in leg)
- ❒ Emphysema/COPD
- ❒ Fibromyalgia
- ❒ Gout
- ❒ Heart Attack
- ❒ Heart Beat is Irregular
- ❒ Heart Murmur
- ❒ Heart Disease
- ❒ Heart Pacemaker/AICD
- ❒ Hepatitis
- ❒ High Blood Pressure
- ❒ High Cholesterol
- ❒ Hypothyroid (low)
- ❒ HIV/AIDS
- ❒ Kidney Dialysis
- ❒ Kidney Disease
- ❒ Kidney Transplant
- ❒ Mental Illness _____
- ❒ Multiple Sclerosis (MS)
- ❒ Osteoporosis
- ❒ Parkinson's
- ❒ Peripheral Arterial Disease (PAD)
- ❒ Peripheral Neuropathy
- ❒ Phlebitis
- ❒ Psoriasis
- ❒ Pulmonary Embolism
- ❒ Raynaud's Disease
- ❒ Rheumatoid Arthritis
- ❒ Seizures
- ❒ Sickle Cell Anemia/Trait
- ❒ Sleep Apnea
- ❒ Stomach Ulcers
- ❒ Stroke
- ❒ Other _____

CURRENT Review of Systems (Please check all items that apply **currently or recently**)

1. Constitutional Symptoms	❒ Fever	❒ Chills	❒ Headache	❒ No symptoms
2. Eyes	❒ Blurred Vision	❒ Double Vision	❒ Eye Pain	❒ No symptoms
3. Ears, Nose, Throat, Mouth	❒ Hearing Loss	❒ Sore Throat	❒ Sinus Problem	❒ No symptoms
4. Cardiovascular	❒ Chest Pain/Pressure	❒ Calf Cramping	❒ Heart Palpitations	❒ No symptoms
5. Respiratory (Lungs)	❒ Shortness of Breath	❒ Wheezing	❒ Frequent Cough	❒ No symptoms
6. Gastrointestinal	❒ Nausea/Vomiting	❒ Heartburn	❒ Abdominal Pain	❒ No symptoms
7. Genitourinary	❒ Painful Urination	❒ Urinary Frequency	❒ Urine Retention	❒ No symptoms
8. Musculoskeletal	❒ Joint Pain	❒ Joint Swelling	❒ Stiffness	❒ No symptoms
9. Skin	❒ Foot Ulcers	❒ Discoloration	❒ Rash	❒ No symptoms
10. Neurological	❒ Numbness/Tingling	❒ Tremors	❒ Paralysis	❒ No symptoms
11. Psychiatric	❒ Addiction to Alcohol	❒ Depression	❒ Anxiety	❒ No symptoms
12. Endocrine	❒ Fatigue	❒ Excessive Thirst	❒ Heat Intolerance	❒ No symptoms
13. Hematologic/Lymphatic	❒ Foot or Ankle Swelling	❒ Swollen Glands	❒ Bleeding Problems	❒ No symptoms
14. Allergic/Immunologic	❒ Recent Asthma Attack	❒ Seasonal Allergies	❒ Drug Allergies	❒ No symptoms

ALLERGIES **SEVERITY** **TYPE OF REACTION**

What is the Allergy? (medication, OTC, substance)	Very mild	mild	moderate	severe	List Symptoms (e.g., hives, swelling, breathing problem)

CURRENT MEDICATIONS

Medication/Dose	What for?	Medication/Dose	What for?	Medication/Dose	What for?
1.		2.		3.	
4.		5.		6.	
7.		8.		9.	

Signature of Patient/Legal Guardian: _____ **Date**: _____

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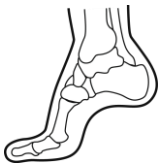

Dr. Will A. Rosena, DPM

Podiatric Surgeon

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FINANCIAL POLICY for Dr. Will A. Rosena, DPM

Welcome and thank you for choosing Dr. Will A. Rosena, DPM. We are committed to providing you with the highest quality medical care in a competent, compassionate, and efficient manner. Please review our financial policy below.
If you have any questions, please feel free to discuss them with our friendly staff.

1. Insurance Coverage: It is very important for you to realize that your insurance policy is a Contract between **You and your Insurance Company**. Our fees are the same for every patient and your payment amount is determined by the insurance company and policy you have selected. As a courtesy, we will file your insurance claim for you. This allows the insurance company to pay the doctor's office directly. We are a specialist office and it is always wise to verify your insurance benefits, co-pays, and deductibles prior to your visit or procedure. We will make a copy of your insurance card and driver's license during your initial visit. Existing patients need to inform us of any changes in insurance coverage or demographics that may have occurred since your last visit.

2. 'No Show' or No Notice Cancellation: There will be a $50 fee when patients fail to show up for their scheduled appointment and when they cancel their appointment without 24 hours' notice. This fee must be paid before seeing Dr. Rosena again.

3. Co-Payments: Most insurance plans have a Co-Payment ('co-pay'). This is an amount you must pay upon each visit to a doctor. Our policy is to collect your co-payment at the time of service. If you are not prepared to pay the co-payment, the visit will be rescheduled. We accept Cash, Check, Debit Card, Visa, MasterCard and Discover.

4. Deductibles: In addition to the co-payment, most plans also have an annual deductible. A deductible is an amount the patient must pay out of pocket before your insurance coverage begins. If you have not met your deductible you will be billed for the expected insurance amount. Payment is expected at the time of service. In the event there is a balance due from you after your insurance carrier has paid its portion, we will bill you. We would appreciate prompt payment of your bill after the first statement. If you do not understand the reason you owe a balance, you should contact your insurance company, so they can explain the details of your insurance plan. If your account becomes past due, we will refer the overdue balance to an outside collection agency and are reported to the credit bureau. All collection fees, attorney fees and court fees shall become the patient's/responsible party's responsibility in addition to the balance due to the office. Then, future services will be billed on a pre-payment basis only.

****** Patients with a deductible will be required to pay $100 at each visit until their deductible has been met. ******

5. Referrals: If you are enrolled in an HMO, which requires a referral from your Primary Care Physician (PCP), it is your responsibility to make sure our office has a copy of the referral. You are responsible for keeping track of the visits your insurance allows and the expiration date of your referral. If a referral is not in place, your appointment may be rescheduled, or any services received without a referral or proper authorization will be your financial responsibility.

6. Non-Covered Services: Your insurance plan may not cover all services, procedures, and/or products provided to you for your treatment. In the event your health plan determines a service or product to be "non-covered," you will be responsible for paying the total charges at the time of your visit or upon receipt of our billing statement.

7. Forms: There will be a prepaid fee of $20 per form for completing individual medical forms, disability forms, work restriction forms, FMLA forms, employer forms, school forms, etc. Payment is due at the time that you request the forms be completed. Please allow 7 business days for the completion of these forms.

8. Returned Checks: A $35 fee will be charged for any checks returned by the bank.

9. Custom Orthotics: Our staff will attempt to determine your insurance coverage for custom orthotics, but if at the time of your visit, insurance coverage has not been determined, you will be responsible for $150, which will be applied to the cost of your orthotics. The balance of the orthotics will be due at the time the orthotics are dispensed (i.e., picked up). If your insurance company pays all or a portion of the orthotic cost and this results in an overpayment on your account, a refund will be made to you. Our cash pay price for 1 pair of custom orthotics is $300. When you agree to have custom orthotics made, you are agreeing that you will be financially responsible for the cost of the device regardless of insurance coverage. If your orthotics are not picked up within 30 days, we will mail them to you and charge your account for the orthotics as well as the shipping cost.

Please sign below if you have read, understand and agree to the above nine financial policies of Dr. Will A. Rosena, DPM.
I understand that I am financially responsible for any deductible, co-insurance, co-pay, non-covered service or unmet balance and any other charges my insurance may not cover.

Signature of Patient or Responsible Person: _____

Printed Name: _____ Date: _____

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DR. WILL A. ROSENA, DPM
PODIATRIC SURGEON
Saving Limbs – Enhancing Lives

CONSENT FORM for Treatment, Payment, and Healthcare Operations

Please read carefully and ask any questions you might have. If you would like to consent, please sign and date below.

1. Consent for Treatment: I hereby authorize Dr. Will A. Rosena, DPM to prescribe, administer, and perform such physical examinations, radiology examinations, laboratory tests, anesthesia, medications, durable medical equipment, hospital care, procedures and surgery as necessary or advisable in the diagnosis and treatment of my condition. I understand that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been or will be made regarding the results of examinations or treatments in this clinic.

2. Assignment of Benefits: In consideration of any services rendered to me by Dr. Will A. Rosena, DPM, I hereby authorize and assign any and all reimbursement pertaining to said services to be made on my behalf and paid directly to Dr. Will A. Rosena, DPM. If my insurance benefits are provided to me through Medicare, I hereby authorize and assign any and all reimbursements made under my Medicare plan, which pertains to any services provided to me by Dr. Will A. Rosena, DPM.

3. Authorization to Release Information: I authorize Dr. Will A. Rosena, DPM to release and disclose any Private Health Information about me that pertains to any and all medical care, tests, treatment, or advice that was rendered to me by Dr. Will A. Rosena, DPM to any physicians, practitioners, insurance companies, third party payers, authorized agents, claims review organizations, support staff or facility involved in my plan of care or transfer of care and/or Medicare in order to process a claim and/or payment on my behalf.

4. HIPAA Notice of Privacy Practices: I acknowledge that a copy of the HIPAA Notice of Privacy Practices will be made available to me at my request, and that I have read or had the opportunity to read and I understand the Notice.

5. Payment Agreement: I understand that by providing a valid and current insurance card prior to services being rendered, Dr. Will A. Rosena, DPM will file a claim to my insurance company but that does not guarantee payment, which ultimately I am responsible for. I hereby accept and assume financial responsibility for any covered or non-covered services rendered to me.

Please sign below if you have read, understand and agree to the above five statements.

Signature of Patient or Responsible Person: _____

Printed Name: _____ Date: _____

AUTHORIZATION TO TREAT A MINOR PATIENT IN THE ABSENCE OF PARENT/GUARDIAN

Name of Minor Patient: _____ Date of Birth: _____

I, _____ certify that I am the parent/legal guardian of _____.
(print adult's name and put your relationship to the child in brackets)

❒ I authorize _____ to bring my child to office visits with Dr. Will A. Rosena, DPM.
(name of person bringing child to office)

❒ I, _____ authorize the minor child, named above, to come alone for office visits with
(name of parent/legal guardian)
Dr. Will A. Rosena, DPM.

❒ This authorization is effective as of _____ (date) and expires ❒ never ***or*** ❒ _____(date).
I reserve the right to revoke this authorization at any time by notifying Dr. Will A. Rosena, DPM in writing.

Signature of Parent/Legal Guardian: _____ SS#:_____ Date: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

PODIATRY OFFICE:
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