ADVANCED FOOT & ANKLE CENTER

MARIO VOLOSHIN, DPM, FACFAS.
ABFAS Board Certified in Foot Surgery.
ABFAS Board Certified in Reconstructive Rearfoot and Ankle Surgery.

LESTER N. DENNIS, DPM, FACFAS.
ABFAS Board Certified in Foot and Ankle Surgery.

PERSONAL HEALTH INFORMATION

Name _____ Date of Birth _____/_____ /_____

Address/City/State/Zip_____

Height_____ Weight:_____ SS _____-_____-_____ Sex: M/ F Single/Married

Home Phone ( ) _____-_____ Cell Phone ( ) _____-_____

Work Phone ( ) _____-_____ EMAIL _____

Occupation_____ Employer_____

Primary Care Doctor_____ Phone ( ) _____-_____

Date of last visit with Primary Care Doctor_____

Pharmacy _____ Pharmacy Zip Code _____

Emergency Contact_____ Phone ( ) _____-_____

Reason for visit/symptoms:_____
When did this begin? _____Who else treated this problem: _____
Is the reason for this visit a result of an accident at work or a motor vehicle? YES / NO

Health Problems You (Y) and Your Family (F) currently have or have ever had:

Diabetes	Anemia	Rheumatic Fever
Heart Disease or Murmur	Phlebitis	Rheumatoid Arthritis
High Blood Pressure	Hepatitis or Liver disease	Gout or Podagra
Stroke	Asthma/Breathing Problems	Epilepsy
Glaucoma	AIDS or HIV	Thyroid Problems
Kidney Disease	GI Ulcer or Gastritis	Tuberculosis
Bleeding Problems	Cancer	Mental Disorder

Other_____
Do you take any medications? (Please LIST name and dose) _____
_____
Do you have any Allergies to Medications, Latex, Iodine, or Other?_____
_____
Do you smoke? Yes / No How much? _____ If you smoked in the past, how long?_____
Do you drink alcohol or take drugs?_____
Did you have ANY surgeries? (Body Part, Type, Date) _____
_____

165 Nassau Avenue, Brooklyn, N.Y., 11222
Tel (718) 389 – 4404 Fax (718) 389 – 5317

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INSURANCE INFORMATION

Primary Insurance:

_____

Insurance ID#: _____

Group ID#: _____

Secondary Insurance:

_____

Insurance ID#: _____

Group ID#: _____

Relationship to Insured: Self/ Spouse/ Child/ Other

Name of Insured: _____ Date of Birth: ____/_____ /_____

No Fault Claim #_____

Date of Injury_____Employer _____

Insurance Carrier/ No Fault Insurance Name_____

Claim Adjuster Name_____Phone #_____

_____I consent to receive automated text and voice messages through Practice Fusion regarding my appointments at the phone number I have provided to Advanced Foot And Ankle.

☐ I authorize this office to electronically retrieve my prescription records from my pharmacy.

HIPPA Acknowledgement:

I, the undersigned, certify that I (or my dependent) have current insurance coverage with the carrier currently on file with Mario Voloshin DPM, PC. All insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Voloshin / Dr. Dennis to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.
I have received my HIPAA Privacy Policy and understand my rights.

_____ _____
Responsible Party Name Today's Date

_____ _____
Responsible Party Signature Relationship to Patient

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FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.You must inform the office of all insurance changes and authorization/referral requirements.**Your Insurance Policy is a contract between YOU and YOUR insurance company.** As a courtesy, we will file your insurance claim for you if you assign benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. As our patient, YOU are responsible for all authorizations/referrals needed to seek treatment in this office.

□**APPOINTMENTS** – 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of $25 may then be added to your account.

□**REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral you will be personally responsible for that day's services.

□**CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the copay at each visit.

□**OUT OF NETWORK PLANS –** Prior to providing these non-emergency services, we hereby disclose to you that our office does not participate with your plan **(Multiplan, GHI, Magnacare.)** Additionally, Dr. Dennis does not participate with (**Blue Cross Blue Shield, The Empire Plan Nyship, Multiplan, Magnacare**) and these services will be billed out of network, upon your request we will provide you with the anticipated costs. Your network and hospital affiliations are available online (http://www.magnacare.com/ http://www.emblemhealth.com/en/Members.aspx, http://www.multiplan.com, http://www.empireplanproviders.com/myuhc.htm) . You will be responsible for any balance your plan indicates as due on their explanation of benefits form. **We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their coinsurance and deductible.** If we do not 'participate' with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Mario Voloshin DPM, PC for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

□**SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

□**MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one. Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Mario Voloshin DPM, PC for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

□**DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Mario Voloshin DPM, PC will not be involved with separation or divorce disputes. You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

WE ACCEPT CASH, CHECKS, CREDIT CARDS VIA SQUARE SERVICE.
THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: _____ DOB: _____

Signature: _____ Date: _____

Responsible Party: _____ Relationship: _____