WELCOME TO OUR OFFICE

RIPEPI & ASSOCIATES FOOT and ANKLE CLINICS, INC

Date: _____ Sex: □Male □Female Office: □Parma □Rocky River

Patient Name: _____

Street Address: _____

City: _____State _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Social Security Number: _____ Birthdate: _____ Age: _____

Guarantor Name: _____ Relationship: _____

Guarantor Birthdate: _____ Social Security Number: _____

Name of Employer: _____Occupation: _____

Employer Address: _____Phone: _____

Family Physician: _____Phone: _____

Referred by: □phone □book □other patient □physician □newspaper □mailer □other

Marital Status: □Married □Single □Divorced □Widow/er

Emergency Contact: _____Phone: _____

Relationship: _____

Medical History

Please check if you have any of the following illness: Do you smoke? : □yes □no

□mitral valve prolapsed	□ stomach ulcers	□ lung disease	□ joint implants	□ osteoporosis
□ heart murmer	□ kidney disease	□bone infection	□ epilepsy	□ CHF
□ diabetes Type ___	□ hepatitis Type ___	□ pneumonia	□ arthritis	□ COPD
□ gout	□ rheumatic fever	□ blood disease	□ polio	□ circulatory problems
□ blood clots	□ stroke	□ tuberculosis	□ asthma	□ liver disease
□ high blood pressure	□cancer	□ heart disease	□ acid reflux	□ thyroid problems

□ Medical Condition NOT Listed _____

Patient Shoe Size: _____

Briefly state your foot problem: _____

How long have you had this problem? _____Have you been treated for this? _____

List all medications you are taking: _____

List all drug allergies: _____

Patient Name: _____ Date: _____

IF YOU HAVE MEDICARE, PLEASE READ AND SIGN

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER Title XVIII of the Social Security Act is correct. I authorize any hold of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carries any information needed for this or a related Medicare claim. I request that payment of authorized benefits be paid on my behalf. I assign the benefits payable for covered Medicare services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

I request that payment under the medical insurance program be made either to me or Ripepi & Associates Foot and Ankle Clinics, Inc. on any bills for service furnished me by Ripepi & Associates Foot and Ankle Clinics, Inc.

Signature of Patient: _____

Date: _____

IF YOU HAVE PRIVATE INSURANCE, PLEASE READ AND SIGN

STATEMENT TO PERMIT PAYMENT OF INSURANCE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT

I authorize any holder of medical or other information about me to release to my insurance carriers any information needed for this or a related claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to my insurance company for payment to me.

I request that payment under Medical Insurance Program be made to either to me or Ripepi & Associates Foot and Ankle Clinics, Inc.

Signature of Patient: _____

Date: _____

RIPEPI & ASSOCIATES FOOT and ANKLE CLINICS, INC

Patient Consent for Use and Disclosure of Protected Health Insurance

With my consent, **Ripepi & Associates Foot & Ankle Clinics, Inc.** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Ripepi & Associates Foot & Ankle Clinics, Inc.** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Ripepi & Associates Foot & Ankle Clinics, Inc.** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Ripepi & Associates Foot & Ankle Clinics, Inc.** Privacy Officer at 6688 Ridge Road, Parma, Ohio 44129.

With my consent, **Ripepi & Associates Foot & Ankle Clinics, Inc.** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **Ripepi & Associates Foot & Ankle Clinics, Inc.** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointments reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, **Ripepi & Associates Foot & Ankle Clinics, Inc.** may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Ripepi & Associates Foot & Ankle Clinics, Inc.** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Ripepi & Associates Foot & Ankle Clinics, Inc.** use and disclosure of my PHI to carry out TPO.

I may revoke consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent **Ripepi & Associates Foot & Ankle Clinics, Inc.** may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

PRINT Name of Patient Date

RIPEPI & ASSOCIATES FOOT & ANKLE CLINICS, INC.

Medicine and Reconstructive Surgery of the Foot, Ankle and Lower Leg / Podiatry

FINANCIAL STATEMENT POLICY

Welcome and thank you for choosing our office for your foot and ankle care. In our effort to provide personalized care in the most efficient and economical manner possible, we ask that you take a few moments to read our Financial Policy and fill out the demographic and health history forms for your medical file. If at any time you have a question regarding our office policies, do not hesitate to contact us and we will be happy to help you.

Your clear understanding of our Financial Policy is important to our professional relationship. We are a Medicare provider and also a provider for most PPO and HMO plans in our area. **It is your responsibility to make sure we are on your insurance plan**. **If your insurance requires a referral or prior authorization, it is your responsibility to make sure that it is in place prior to your appointment**. We will be glad to assist you if you need help.

We will bill your insurance company as a courtesy to you. **All co-payments are due at the time of your visit. If you have an unmet deductible we pre-collect 60% of the charges incurred that your insurance will apply towards your deductible.** If you have a secondary insurance company, we will bill them one time. If your secondary insurance does not pay the balance due within 45 days, the balance will be billed to you and due at that time.

Balances/Collection Fees: If balances are not paid within **14 days** from the statement date, a **$12.00 rebilling fee** will be added to each additional statement sent for the unpaid balance. A consistent attempt will be made to collect outstanding account balances. Past due accounts, more than **90 days**, will be turned over to our collection agency.

Complete payments for all podiatry soft goods, medical products, and supplies are due at the time they are dispensed.

A 24-hour notice is requested for cancellations of appointments. If you fail to show for an appointment, you personally may be charged a $25.00 no-show fee. We will try to accommodate you in rescheduling your appointment as soon as possible.

I have read the above policy and understand my financial responsibility to Ripepi Foot & Ankle Clinics, for medical services provided. I agree to pay Ripepi Foot & Ankle Clinics any balance due/or unpaid by my insurance carrier for myself or the below named person.

Printed Name: _____ Signature: _____

Financially Responsible Party:

Printed Name: _____ Signature: _____

Relationship to Patient: _____ Date:_____

NON-COVERED BENEFITS

Date _____

Patient Name_____

DOB _____

Name of Physician: DR. JOSEPH C. RIPEPI

CAREFULLY READ THE FOLLOWING INFORMATION

I UNDERSTAND THAT MY SIGNATURE ON THIS FORM INDICATES THAT I ACKNOWLEDGE THAT ANY TREATMENT AND/OR EQUIPMENT PROVIDED TO ME TODAY MAY BE A NON-COVERED BENEFIT PROVIDED ACCORDING TO THE TERMS OF MY INSURANCE CONTRACT WITH _____.

EVEN THOUGH I AM AWARE THAT THESE SERVICES AND/OR EQUIPMENT MAY NOT BE A COVERED BENEFIT WITH MY INSURANCE PLAN, I AM GIVING DR. JOSEPH C. RIPEPI PERMISSION TO PROVIDE ME WITH THIS NON-EMERGENT MEDICAL CARE OR EQUIPMENT.

I UNDERSTAND AND AGREE THAT THE CHARGES INCURRED AS A RESULT OF THIS NON-COVERED SERVICE OR EQUIPMENT IS MY PERSONAL FINANCIAL RESPONSIBILITY.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

6688 Ridge Road, Suite 1320 * Parma, Ohio 44129 * 440.843.3692 * Fax 440.884.4760
19109 Old Detroit Road * Rocky River, Ohio 44116 * 440.331.9383 * Fax 440.356.2630

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