RAHIL BAXAMUSA, D.P.M

WELCOME TO OUR OFFICE

PLEASE PRINT THE FOLLOWING INFORMATION FOR OUR RECORDS:

PATIENTS NAME:_________________________AGE:_______ DOB:_______

HEIGHT:________WEIGHT:________(CIRCLE) MARRIED SINGLE WIDOWED DIVORCED

PERSON RESPONSIBLE FOR PAYMENT OF FEES:________________________________

IS PATIENT COVERED BY MEDICAL INSURANCE ( ) YES ( ) NO

SOCIAL SECURITY NUMBER OF INSURED: ______________________________________

SOCIAL SECURITY NUMBER OF PATIENT: ______________________________________

____

PATIENT'S RESIDENCE ADDRESS: ____

CITY:_________STATE:_________ZIP: __________ PHONE NUMBER: _________________

PATIENT EMPLOYEED BY: ______________________BUSINESS PHONE: _____________

OCCUPATION:___________________ BUSINESS ADDRESS:__________________________

INSURED DATE OF BIRTH:____________

HOW DID YOU HEAR ABOUT THE PRACTICE? (CIRCLE ONE)

INTERNET/GOOGLE FRIEND/FAMILY DOCTOR REFERRAL (WHO? ______________)

INSURANCE COMPANY FACEBOOK OTHER _______________________

-MEDICAL INFORMATION-

WHAT IS YOUR CURRENT COMPLAINT OR SYMPTOMS?____________________________

____

DO YOU HAVE ANY ALLERGIES TO MEDICINE? ( ) YES ( ) NO

IF YES CIRCLE: PENICILLIN ASPIRIN CODEINE NOVACAINE ADHESIVE TAPE

LIST ANY OTHERS:____

DAILY MEDICATION: ____

HISTORY OF: (CIRCLE ANY WHICH APPLY & LABEL WITH "P" PERSONAL AND "F" FAMILY)

KIDNEY DISEASE DIABETES STOMACH ULCER COLITIS/ILEITIS HIGH BLOOD PRESSURE

ARTHRITIS BURSITIS EXCESSIVE OR ABNORMAL BLEEDING

LIST ANY OTHER MAJOR PAST AND/OR PRESENT ILLNESSES: __________________________

OVER ->

HAVE YOU HAD SURGERY? (CIRCLE ANY WHICH APPLY) TONSILLECTOMY APPENDECTOMY HYSTERECTOMY REMOVAL OF WARTS OR GROWTHS

LIST ANY OTHER SURGERY: ____

____

HAVE YOU BEEN HOSPITALIZED FOR ANY REASON OTHER THAN CHILDBIRTH OR SURGERY?

IF YES GIVE APPROXIMATE DATES AND REASONS: ____________________________

____

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS: (CIRCLE, IF YES)

PAIN IN LOWER BACK CRAMPS IN LEGS OR FEET SWELLING OF ANKLES

DELAYED HEALING NUMBNESS OR BURNING OF FEET EXCESSIVE SKIN DRYNESS

EXCESSIVE PERSPIRATION SEVERE FOOT PAIN UPON RISING IN THE MORNING

PERSISTENT COLDNESS OF FEET FOOT ODOR

FAMILY PHYSICIAN: ____

____

OFFICE POLICIES

1. **THE FEES IN THIS OFFICE ARE CONSISTENT WITH "USUAL AND CUSTOMARY' FEE STATISTICS FOR THE SERVICES RENDERED. PAYMENTS ARE REQUIRED AS SERVICES ARE RENDERED. UNLESS OTHER SUITABLE ARRANGMENTS ARE MADE IN ADVANCE.**
2. **WE WILL BE HAPPY TO DISCUSS ANY QUESTIONS YOU MAY HAVE REGARDING FEES.**
3. **WE WILL COMPLETE TWO (2) INSURANCE FORMS AT NO CHARGE, PER CONDIOTION. A CHARGE MUST BE MADE FOR COMPLETING ADDITIONAL FORMS.**

EMERGENCIES

WE KNOW THAT EMERGENCY PROBLEMS DO NOT ALWAYS ARISE DURING OOUR OFFICE HOURS. PATIENTS NEED NOT HESITATE TO CALL OUR OFFICE AT ANY TIME. OUR OFFICE NUMBER: 815- 455- 3788, IS ANSWERED 24 HOURS A DAY, AND THW DOCTOR CAN BE REACHED IN CASE OF AN EMERGENCY.

WE ARE NEVER TOO BUSY....

AT TIMES, THINGS CAN GET HECTIC AND WE MAY BE A LITTLE BUSIER THAN USUAL. BUT IF YOU HAVE QUESTIONS ABOUT YOUR CONDITION, THE TREATMENT YOU ARE RECEIVING, OR ANY OTHER ASPECT IF CARE IN THIS OFFICE, JUST ASK. WE DO NOT WANT TO BE TOO BUSY TO ANSWER YOUR QUESTIONS.

SIGNATURE: ______________________________

DATE: ______________________________

OVER ->

GENERAL CONSENT FORM

DR. RAHIL BAXAMUSA

CONSENT FOR TREATMENT

I consent for evaluation and treatment of the condition for which I, my child or my dependent have come to Dr. Rahil Baxamusa.

CONSENT FOR RELEASE OF INFORMATION

I consent to routine release of my medical information necessary for billing, collections, and auditing purposes. My medical information may be released to insurance companies, and third-party payors, and claims review organizations. I consent to routine release of my medical evaluation as necessary for medical treatment, such as ordering consultations, special evaluations, and laboratory tests. I release and hold harmless Dr. Rahil Baxamusa and his employees from any liability that may arise from the release of medical information in accordance with this consent. I will tell you if I wan to inspect the information being released.

CONFIRMATION OF APPOINTMENTS & OTHER OFFICE MATTERS

I give you permission to call to confirm appointments	( ) **YES**	( ) **NO**
You may call me at home	( ) **YES**	( ) **NO**
You may leave a message at home	( ) **YES**	( ) **NO**
You may call me at work	( ) **YES**	( ) **NO**
You may leave me a message at work	( ) **YES**	( ) **NO**
You may call my cell number	( ) **YES**	( ) **NO**

ASSIGNMENT OF BENEFITS & AGREEMENT FOR PAYMENT

I authorize my insurance company to pay benefits directly to Dr. Rahil Baxamusa. I am financially responsible for any unpaid balance on my account. If I am the named insured, I agree that any credit balance on an account of anyone else in my family.

PATIENT RESPONSIBILITY FOR PRE-CERTIFICATION

I am responsible for notifying my insurance company to obtain authorization before service is provided.

NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

OVER ->

PATIENT COPIES

I do ____ I don't ____ want a copy of the Notice of Privacy Practices

I do ____ I don't ____ want a copy of the Summary of Notice of Privacy

I do ____ I don't _____want a copy of this consent form

PATIENT NAME: ___________________________

PATIENT SIGNATURE: ___________________________________

DATE: ________________

DR. RAHIL BAXAMUSA D.P.M

Acceptance of Insurance Assignment and Financial Policies

Please initial each line showing you agree to abide with the following:

_____ I authorize Rahil Baxamusa, DPM and it's agents to furnish my insurance companies with all necessary information concerning diagnosis and treatment for myself or dependents under compliance of the Health Insurance Portability and Privacy Act of 1996 (**HIPPA**)

_____ I assign the medical and/or surgical benefits that my dependents and I are entitled to under my health insurance plan to Rahil Baxamusa, DPM and treating physicians.

_____ An estimate will be provided before any services are rendered.

_____ I agree to pay all balances accrued with Rahil Baxamusa, DPM and my treating physicians for services rendered. Cash, personal checks, cashier's checks, money orders, credit/ debit cards are accepted. Other payment agreements set forth by my insurance plan may restrict or limit the ability of Rahil Baxamusa, DPM to collect payment in full.

_____ I understand I am responsible for all co-payments, deductibles, and co-insurance. Co-payments must be paid prior to services being rendered.

_____ I understand some medical/surgical and/or durable medical equipment services will require a pre-paid deposit. All deposits will be applied to any outstanding charges for those services rendered. Any excess funds remaining after receiving insurance remittance will be refunded promptly.

____ Rahil Baxamusa, DPM does not generally arrange payment plans. In situations of extreme financial hardship, I will discuss my situation with the treating physician and/or the office manager.

____ I understand that I am responsible for any outstanding balance remaining after insurance remittance has been received. A collection fee of 10% will be applied to outstanding balances past 180 days. Any balance not paid after 180 days may be referred to an attorney for collection. All legal and collection fees will be the guarantor's responsibility.

OVER ->

<u>*********FOR MINOR PATIENTS ONLY **********</u>**

_____ In the case of divorced parents, payment is expected from the person signing this document and will be considered the guarantor for all payments for any services provided. Rahil Baxamusa, DPM will not recognize any divorce decrees regarding reimbursement for medical services for any minor child of divorced parents.

********<u>COLLEGE STUDENTS WITH PARENT'S INSURANCE, PLEASE INITIAL BELOW</u>*************

_____College students with health insurance under their parent's name will not be treated by any physician from Rahil Baxamusa, DPM without written permission from the parent or guardian. Original signature or fax is allowable. The student being treated gives permission to Rahil Baxamusa, DPM to contact parents regarding his or her health conditions per HIPPA requirements. Parents agree to be responsible for all charges unless other arrangements are made in advance.

Patient Name: ____

Signature of Patient/Responsible Party: ____

DATE: ______________________

RAHIL BAXAMUSA, DPM

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH IMFORMATION

The individual whose signature appears below hereby attests to the following statements:

With my consent, Dr. Rahil Baxamusa, DPM., may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (Please refer to, Dr. Rahil Baxamusa, DPM, Notice of Privacy Practices for a more complete description of such uses and disclosures.)

With my consent, Dr. Rahil Baxamusa, DPM may disclose my PHI to the following individuals (family, relatives, or friends) who may assist in my care.

NAME	RELATIONSHIP	HOME #	WORK #	CELL #

PLEASE INDICATE NAME, CONACT NUMBERS, AND RELATIONSHIP OF INDIVIDUALS TO WHOM DR. RAHIL BAXAMUSA, DPM MAY RELEASE PHI.

I have the right to review the Notice of Privacy Practices prior to signing this consent, Dr. Rahil Baxamusa, DPM reserves the right to revise its Notice of Privacy Practices at any time. A written copy of our Notice of Privacy Practices may be obtained by forwarding a written request to our office.

CONSENT FOR CALLS TO HOME

With my consent, Dr. Rahil Baxamusa, DPM may call my home or designated location and leave a message on my voice mail or with a person in reference to any item that may assist, Dr. Rahil Baxamusa, DPM in carrying out TPO.

OVER ->

Such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

CONSENT FOR MAIL

With my consent, Dr. Rahil Baxamusa, DPM may mail to home or other designated location any item that may assist, Dr. Rahil Baxamusa, DPM in carrying out TPO such as appointment reminder cards and patient statement as long as they are marked CONFIDENTIAL.

CONSENT FOR E-MAIL

With my consent Dr. Rahil Baxamusa, DPM, may e-mail to my designated e-mail address any message in reference Dr. Rahil Baxamusa, DPM may contact me for TPO use, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results, among others.

I have the right to request that, Dr. Rahil Baxamusa, DPM restricts how it uses or discloses my PHI to carry out the TPO, However, Dr. Rahil Baxamusa, DPM 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, Dr. Rahil Baxamusa, DPM's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent, Dr. Rahil Baxamusa, DPM has already made disclosure in reliance upon my prior consent. If I do not sign this consent, Dr. Rahil Baxamusa, DPM may decline to provide services to me.

Patient Signature:____ **Date:**______________

Patient Printed Name: ____

DR. RAHIL BAXAMUSA, DPM

NOTICE TO MEDICARE BENEFICIARIES ABOUT COVERAGE FOR FOOT CARE AND SERVICES

Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits. When you receive foot care services and items that are not covered Medicare benefits, you must pay them personally or through any other insurance that you may have.

The purpose of this advance notice is to help you make an informed choice about whether you want to receive these foot care services or items, knowing that you will have to pay for them yourself. We do not send claims to Medicare for foot care services or items that are excluded from Medicare coverage.

Before you make a decision, you should read this entire notice carefully.

The Medicare program does not cover most routine foot care and flat foot care. The Medicare law clearly excludes coverage for services in connection with "the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care." The Medicare law clearly excludes coverage for services in connection with "treatment of flat foot conditions and the prescription of supportive devices thereof" or with "the treatment of subluxations of the foot." Providers may not be required to submit Medicare claims for such services.

NOTE: A narrow exception permits coverage of some foot care services when certain conditions result in severe circulatory problems or areas of diminished sensation.

The Medicare program does not cover most orthopedic shoes or other foot support (orthotics). The Medicare law clearly excludes coverage for services in connection with "orthopedic shoes or other supportive devices for the feet."

NOTE: A narrow exception permits coverage of special shoes and inserts for certain patients with diabetes.

This means that Medicare will not pay for most routine foot care, flat foot care, orthopedic shoes, or orthotics, because they ae not Medicare covered benefits. Payment for these excluded foot care services and items is your responsibility.

OVER ->

If you have any additional questions concerning Medicare coverage for foot care services or items, you can contact Medicare at 1-800-MEDICARE (1-800-633-4227).

This notice is published by: American Podiatric Medical Association (APMA), P.O. Box 9312 Georgetown Road, Bethesda, MD 20814-1621. The Centers for Medicare & Medicaid Services has reviewed this APMA notice about foot care coverage and confirmed the accuracy of its content. This notice is only a general summary of foot care exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.

Medicare Beneficiary Signature:___________________________ Date:________________

DR. RAHIL BAXAMUSA, DPM

MEDICAL APPOINTMENT CANCELLATION/ NO SHOW POLICY

Thank you for trusting your medical care to Dr. Rahil Baxamusa, DPM. When you schedule an appointment with our practice, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24hrs prior to your scheduled appointment. Please see our Appointment Cancellation/ No Show Policy below:

- **Effective** January 1, 2019 any established patient who fails to show or **cancels/reschedules** an appointment and has not contacted our office with at least **24 hour** notice will be considered a **No Show** and charged a **$40.00** fee.
- Any established patient who fails to **show** or **cancels/reschedules** an appointment with no **24 hour** notice a **second** time will be charged an additional **$40.00** fee.
- If a third No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be dismissed from our practice.
- The fee is charged to the patient, not the insurance company.
- As a courtesy, when time allows, our office makes reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office manager, who may be able to waive the No Show fee. You may contact the practice of Dr. Rahil Baxamusa, DPM 24 hours a day, 7 days a week at the number below. Should it be after regular business hours, you may cancel and reschedule all appointments with our 24 hour live answering service.

Dr. Rahil Baxamusa, DPM (815) 455-3788

Patient Name: ____________________________ **Relationship to Patient:** ______________

Signature: _______________________________ **Date:** _________________