

Richard J. Grayson, D.P.M.

40 Avon Meadow Ln, Avon, CT 06001

PATIENT INFORMATION

Patient Name _____ Date Of Birth _____ SS#: _____

Home Address _____

Town _____ ZIP _____

Home Phone _____ Cell # _____ Work # _____

Height _____ Weight: _____ Shoe Size: _____ Have you worn orthotics? Y N

Employer _____ Occupation _____

Emergency Contact _____ Phone _____

Spouse's Name _____ Date of Birth _____ SS# _____

Primary Care/Family Physician: Name _____ Town _____

Who May We Thank For Referring You To Our Office _____

PRIMARY INSURANCE INFORMATION

Primary Insurance: _____ Group #: _____

Member ID #: _____ Copay\$: _____

Name of Policyholder: _____ Relation to Patient: _____

If different than patient:

Policyholder address: _____

(Street)

(City)

(State, Zip Code)

Policy Holder's: Date of Birth: _____ SS#: _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance: _____

Member ID #: _____ Co-pay\$ _____

Name of Policyholder _____ Relationship: _____

If different than patient:

Policyholder address _____

(Street)

(City)

(State, Zip Code)

Policy Holder's: Date of Birth _____ SS#: _____

CURRENT PROBLEM:

What is your present foot problem _____

How long have you been bothered by the above? _____

What have you done for the above problem? _____

PAST MEDICAL HISTORY:

Are you now, or have you been under a physician's care during the past two years? Yes No

Date of your last physical exam: _____ Any recent hospitalizations? Yes No

Are you currently taking any medications? Yes No

If Yes, what medicines (PLEASE LIST) _____

Circle if you have or were treated for the following (circle all that apply):

- | | | | |
|------------|---------------------|---------------------|--------------------------|
| AIDS | Bleeding tendency | Heart disease | Mitral Valve Prolapse |
| Allergies | Cancer | Heart Murmur | Nervous Condition |
| Anemia | Diabetes | Hepatitis | Rheumatic Fever |
| Epilepsy | High blood pressure | Blood clots | Sciatica |
| Arthritis | Glaucoma | Kidney disease | Ulcers |
| Asthma | Gout | Liver trouble | Numbness in feet or legs |
| Alcoholism | Swelling | Shortness of breath | Chest Pain |
| Stroke | Depression | Low back pain | Leg Cramps |
- Other: _____

MEDICATION ALLERGIES Yes _____ No _____ (Please List And Tell What Occurred)

Previous Surgeries (Please List): _____

Do you smoke? Yes No

Drink Alcohol? Yes No How often? Daily Weekly Monthly

Other Medications (vitamins, supplements, etc): _____

FAMILY HISTORY:

Circle if any blood relatives have had:

- | | | | | | |
|-----------|--------|----------|---------------|---------------------|----------------|
| Arthritis | Cancer | Diabetes | Heart Disease | High Blood Pressure | Kidney Disease |
|-----------|--------|----------|---------------|---------------------|----------------|

Any other pertinent information I should know? _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient (Please Print) _____

I request that all communications to me (by telephone, mail or otherwise) by Dr. Richard Grayson and/or his staff be handled in the following manner:

For written communications, address to:

For oral communications, telephone number(s) we can call:

1. _____
2. _____

May we leave a phone message? Yes _____ No _____

May we leave a message with any person? Yes _____ No _____

If no, may we leave a message with specific person(s)? Yes _____ No _____

Relationship(s): _____

Financial Policy for Richard J. Grayson, D.P.M.

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skilled and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

CO-PAYS: Are due at the time of service.

SELF PAY: Payment is due in full at the time of service if you do not have health insurance.

MEDICARE: We are a participating Medicare provider. Medicare and your secondary insurance will be billed for you. You are responsible for your co-pay or any deductible amounts.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance after payment and/or explanation of benefits is received from your primary insurance company.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates that when you visit a specialist, you may need to have a referral from your primary care physician prior to seeking care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of the visit. If a referral is not provided **you are** fully responsible for all services provided if denied by the insurance company.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility. After the third and last notice, your account will be forwarded to collections. An additional 10% fee per month will be added to your account after the first 30 days. In the event your insurance company should send the payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

I have read the above policy regarding my financial responsibility to Richard J. Grayson, D.P.M. for providing medical services to me or the below named patient. I agree to pay Richard J. Grayson, D.P.M. for any amount due after insurance payment has been made by my carrier and any contractual adjustments have been credited or the full amount of all bills incurred by me or the below named if there is no health insurance coverage.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

ASSIGNMENT OF BENEFITS: I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Richard J. Grayson, D.P.M. all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

Patient Name (Please Print): _____

Financial Responsible Party _____

Relationship to patient _____

Signature _____ Date _____