WELCOME

PATIENT INFORMATION

Date _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Soc. Sec. # _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Primary Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. Cange 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____
Name of

Cange
_____ for any services furnished to me by that provider.
Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

_____

Have you ever been to a Podiatrist before
☐ Yes ☐ No
If yes, please list.

Name _____

Last visit _____

Is there any personal or family history of diabetes? ☐ Yes ☐ No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

Athletic activities in which you participate (please list and indicate frequency)

_____

_____

_____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Calluses	☐ Yes	☐ No
Cramps or Numbness in Feet or Legs	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Swelling in Ankles or Feet	☐ Yes	☐ No
Tired Feet	☐ Yes	☐ No

– OVER –

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Allergies to Anesthetics	☐ Yes	☐ No	Eye Problems	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Allergies to Medicine or Drugs	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Foot or Leg Cramps	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Artificial Heart Valves or Joints	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Swelling in Ankles, Feet	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis or Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tired Feet	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No	Neuropathy	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Ear Problems	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Surgeries you have had _____

_____

_____

Hospitalization other than for the surgeries listed _____

_____

Is the reason for this visit auto accident related? ☐ Yes ☐ No If yes, date of auto accident _____

Family physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

☐ Adhesive/Tape
☐ Anticoagulant Therapy
☐ Aspirin
☐ Codeine
☐ Demerol
☐ Iodine
☐ Local Anesthetics
☐ Novocaine
☐ Penicillin
☐ Seafoods
☐ Sulfa

Other _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

As a courtesy, CangePodiatry, DPM, PA Practice, verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan. If your claim processes differently from the benefits we quoted, the insurance company will side with the plan and will not honor the benefit we received.

It is the policy of CangePodiatry, DPM, PA Practice that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, co-pay and/or coinsurance payment at the beginning of each visit. The office manager at your location will explain this information to you prior to your first visit. At the conclusion of your visits with us, you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.

If you are covered by health insurance with Podiatry benefits, we will be happy to bill your insurance. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our office by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100% responsible for all charges incurred. Once again, your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

We highly recommend you also contact your insurance carrier and check into your coverage for Podiatry services. Do not assume that you will not owe anything if you have more than one insurance policy.

<u>Payment Policy</u>

Thank you for choosing us to provide your foot care. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read through, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you have regarding your coverage.

2. **Co-payments and deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services:** Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license or nationally recognized photo identification and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.
6. **Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment:** If your account is over 30 days past due, it will be referred to a collection agency.
8. **Missed appointments:** Our policy is to charge for missed appointments and those that are not cancelled within 48 hours of a set appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understood the payment policy and agree to abide by its guidelines.

_____	_____	_____
Signature of patient or responsible party	Print Name/ Relationship to Patient	Date

CANGEPODIATRY, DPM, PA
7310 Ritchie Highway, Suite 404
Glen Burnie, MD 21061
(T) 410-684-5934
(F) 410-684-5939

PATIENT NAME: _____ DOB:_____

EMERGENCY CONTACT:_____ PHONE:_____

PHARMACY:_____ PHONE:_____

Please initial that you have understood and accept CangePodiatry, DPM, PA Office Policies:

___ALL medical questions and results are discussed in office visits, never over the phone.
___Prescription refills are done during business hours only, and may take up to 3 days.
___Any **controlled medications** require follow up and must be made at the end of each appointment.
___You will be charged a $65.00 fee for no show/same day cancellations.
___ Co-payment is paid at the time of service. If you are unable to do so, your appointment will be rescheduled.
___All fees are due on the day of visit, unless payment arrangements have been made. Cash, credit/debit card, or check is accepted.
___You are responsible for non-covered charges for all procedures done in the office.
___Outstanding balances will be turned over to a collection agency with fees.
___Form requests take 2-3-business days. Cost: $75.00 per entity, paid with drop off.
___I have seen and understood CangePodiatry, DPM, PA Practice Office Policy and Notice.
___For a better understanding of your insurance policy, **YOU** must call your insurance company directly.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

CANGE PODIATRY
PODIATRIC MEDICINE & SURGERY
7310 Ritchie Highway, Suite 404
Glen Burnie, MD 21061
Tel: (410) 684-5934 | Fax: (410) 684-5939
cangepodiatry.com | cangepodiatry@gmail.com

MEDICAL INSURANCE AND FINANCIAL POLICY

We would like to welcome you and thank you for selecting our office! Our objective is to provide "total foot and ankle care with our very personal touch."

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our policy.

The patient is responsible for payment of their health care within a reasonable time, regardless of the processing time of your insurance claim. In circumstances where a claim is pending, or when treatment will be for an extended period of time, it is recommended that a payment plan be initiated. We accept **cash, checks**, **credit card and care credit.**

Balances older than 30 days will be sent to collection and incur a charge. Returned checks are subject to a $75.00 fee. Missed appointments will be billed $65.00 when cancelled without a 48-hour notice. Patients that do not pay their co-pay at time of visit will be charged an additional $25.00.

YOU MUST BE MADE AWARE THAT:

1) Your insurance is a contract between you, your employer, and insurance company. It is your responsibility to understand the benefits of your plan. We cannot guarantee payment of your claims. If your insurance company pays only a portion of your claim or rejects your claim, you and/or the policyholder should make any contact or inquiry. After 90 days from the date of service, you will automatically become responsible for the balance. Payment delays or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.
2) Medicare Patients- Please understand that we participate with Medicare. However, you are responsible for your 20% co-insurance, deductible and any **non-covered** services. If Medicare has provided its reimbursement for services rendered and if your supplemental insurance does not respond within 30 days, then you become responsible for the balance.
3) Fillings of insurance claims are a courtesy that we extend to our patients and all charges are your responsibility. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.
4) If you believe your insurance carrier has erred or not adequately addressed your claims, you may file a grievance or appeal with the Maryland Insurance Administration, (410)468-2244 and/or The Health Advocacy Unit of the Maryland Attorney General, (410)528-1840.

I have read and I understand the above financial policies. These policies are subject to change without prior written confirmation.

_____ _____

PATIENT SIGNATURE DATE

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Tel: (410) 684-5934 | Fax: (410) 684-5939
cangepodiatry.com | cangepodiatry@gmail.com

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Practice's Privacy Notice.

_____	_____	_____
Name of Patient (Print)	Date of Birth	Phone Number

_____	_____
Signature of Patient or Personal Representative	Relationship of Representative

_____	_____
Date	Witness

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PATIENT RESPONSIBILITY

_____ _____
Name of Patient (Print) Date

I,_____, will be responsible for all charges for the dispensement of any device(s), procedure(s), and/or treatment(s) that are performed by Dr. Darlyne Cange.

AFTER SUBMISSION TO MY INSURANCE COMPANY;

I have given permission to the Doctor above to perform treatment.

I do understand that all claims will be billed to my Insurance first and that I will be liable for any charges not covered by my Insurance or Medicare.

I agree to send payment within 30 days to:

DR. DARLYNE CANGE
P.O.BOX 1606
ELLICOTT CITY, MD 21041

_____ _____
Signature of Patient Date

_____ _____
Witness Date