Coastal
Foot & Ankle

PATIENT INFORMATION

Patient name _____Date of birth _____Todays Date_____

Home Address _____ City _____ State _____ Zip_____

Mailing Address_____City_____State_____Zip_____

Home phone (_____) _____-_____ Cell phone (_____) _____- _____ Gender_____

Email address_____Sign up for patient portal YES_____NO_____

Primary care physician (First and Last name) _____Phone_____

When were you last seen by this doctor? _____

Employer_____Phone_____

Whom may we thank for referring you to our office _____

Pharmacy_____ Address_____ Phone (____) ____-_____

Emergency Contact_____Relationship_____Tel:_____

IMPORTANT If applicable, may we leave medical information on your home answering machine, voice mail or with a family member? (Example: appt reminders, insurance coverage info, etc..) Yes/No

ALL INFORMATION IS CONFIDENTIAL. Every attempt will be made to respect confidentiality when communicating with patients. It is our policy to release patient information to other providers only with the written patient consent.

INSURANCE INFORMATION

Primary insurance _____ Policy #_____

Name of policy holder_____ Relationship to patient_____

Secondary insurance _____ Policy #_____

Name of policy holder_____ Relationship to patient_____

Are any of your concerns today related to a workman's comp. case or an automobile accident? YES/NO

Workers Compensation or Motor Vehicle claims need prior written authorization from adjuster.

What is your chief foot/ankle/leg complaint today?_____

_____

How long has it been bothering you? _____ Date of injury?_____

Was this problem previously treated? YES/NO If yes, by whom? _____

Any imaging done? _____If yes, Facility_____Date_____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosed and/or treatment of my feet, ankles, or lower legs. I hereby authorize medical information to be sent to my primary physician.

_____ _____

Signature of Patient Date Signature of Guardian Date

Jonathan Sabourin, DPM FACFAS

PLEASE TURN OVER

If you are under the regular care of any other doctors, or see an endocrinologist or vascular surgeon, please list their names:_____

Medical History: Do you have, or have you ever had any of the following health problems?

AIDS/HIV ____	Diabetes Type I___Type II____	Hypertension ____	Stomach Ulcers ____
Anemia ____	Epilepsy ____	High Cholesterol ____	Thyroid Problems ____
Arthritis ____	GERD ____	Kidney Disease ____	Tuberculosis ____
Asthma ____	Gout ____	Phlebitis ____	Valve/Joint Replacement ____
Bleeding problems ____	Heart Disease ____	Stroke ____	Varicose Veins ____
Cancer/Type _____	Hepatitis ____	Liver Disease ____	Other_____

When was your last Diabetic eye exam?_____Cataract?_____Glaucoma?_____ Retinopathy?_____

Are your immunizations up to date? Flu Shot _____Year_____ Pneumonia _____ Year_____

HAVE YOU EXPERIENCED……

Back Problems	_____	Headaches	_____
Burning, Tingling, numbness in toes	_____	Itchy skin on feet	_____
Dryness of skin	_____	Reaction to local anesthetic	_____
Fainting	_____	Shortness of breath	_____
Foot/Leg cramps while sleeping	_____	Swelling of Feet/Ankles	_____
Foot/leg cramps while walking	_____	Keloid or thick scars	_____

HEIGHT ___'___ WEIGHT _____ SHOE SIZE_____ Single_____ Married_____Widow_____ Other_____

CURRENT MEDICATIONS:

_____mg___	**_____mg_____**	**_____mg_____**
_____mg___	**_____mg_____**	**_____mg_____**
_____mg___	**_____mg_____**	**_____mg_____**

ALLERGIES: DO YOU HAVE ANY ALLERGIES? YES NO

Adhesive tape___ Reaction_____	Local Anesthetics ___ Reaction_____
Sulfa Drugs ___ Reaction_____	Aspirin ___ Reaction_____
Shellfish ____ Reaction_____	Penicillin ___Reaction_____
Demerol ____ Reaction_____	Iodine/Betadine____Reaction_____
Codeine ____Reaction_____	Latex____ Reaction_____

Other _____

SURGICAL HISTORY (Procedure and year) _____

SOCIAL HISTORY: Do you smoke? Yes/No Do you drink alcoholic beverages? Yes/No How often?_____

Do you exercise regularly? Yes No If yes, what activities do you enjoy? _____

FAMILY MEDICAL HISTORY:

_____

OUR POLICY REGARDING YOUR HEALTH INSURANCE

So that we may preserve the best possible relationship with our patients, we hope that the following explanation of our position on Health Insurance Carriers will be helpful:

1. The proper relationship between patients, doctor, and insurance carrier is often misunderstood. We render to you our very best care, and charge you a fee for that service. Just as the insurance companies do not allow us to set their premium rates, we cannot allow them to set our fees or determine which procedures are best for you.

2. Insurance policies vary in the amount that will be paid towards any charges. **Please be aware of your copayment responsibilities, deductibles, co-insurances and In/Out network benefits.** There may be a patient responsibility due after your insurance company has processed your claim. We will bill you for these balances, and expect prompt payment.

3. Many insurance companies today require that patients secure a **INSURANCE REFERRAL** from their Primary Care Physician before being seen by a specialist under certain circumstances. Because there are numerous insurance plans, it's impossible for us to keep track of when referrals are necessary and when they are not. The circumstances vary from plan to plan. As a result, we must insist that each individual patient assume responsibility for securing a referral when they are needed. If you are not sure when you need to get a referral please inquire with your insurance company.If your insurance company rejects our claim for services rendered due to failure to secure a referral from your Primary Care Physician you will be held accountable to pay the bill. It must be clearly understood that the responsibility to secure referrals is that of the patient and not ours. We are always happy to submit a claim to your insurance company for services rendered. If the claim is denied due to lack of referral, you will be responsible for 100 percent of the balance.

4. It is your responsibility to ensure we have up to date insurance information in order to properly process your claim.

By signing this form, I understand and agree to the above statements. I also authorize payment of medical benefits to Coastal Foot & Ankle, Dr. Jonathan Sabourin for services provided to me, or any member of my family, covered under my insurance plan. A copy will be given to me and also put in my medical record.

I authorize the release of any medical or other information necessary to process my medical claims.

Signature _____

Date _____

Jonathan Sabourin, DPM FACFAS

UNDERSTANDING DEDUCTIBLES, COPAYS, AND COINSURANCES

All private health insurance require consumers to pay some of the cost of covered healthcare services. This is called “cost sharing” or “out of pocket” costs. Cost sharing varies with different types of health plans, but most will have a copayment, coinsurance, or deductible amount.

- **Copay**: In a traditional copay plan, you pay a fixed amount per service. The insurance covers the rest of the allowable charge.
- **Coinsurance**: in a coinsurance model, you pay a fixed percentage of each service. The insurance pays the rest of the allowable charge.
- **Deductible**: You pay the entire amount allowed for all services provided until the deductible is met. For example: if you have an annual deductible amount of $500, you would continue to pay for all services out-of-pocket until you have paid a total of $500, after which your insurance would start to pick up the cost of these services.

What counts towards the deductible?

Deductibles only apply to money you spend on covered services that are billed to the insurance plan. Covered services are determined by each individual insurance, and will vary according to which plan you have.

If you receive a service that is not considered covered service by your health plan, then you may be required to pay this amount out of pocket to your provider.

Non-Covered Services

Below are some examples of services provided by Coastal Foot & Ankle that are sometimes non-covered or are applied to deductibles by private insurance companies.

- Injections
- Soft/Hard casts
- Post-Op Radiographs
- Custom & Prefabricated Orthotics
- Crutches
- Post-Op Shoes/Boots
- Routine foot care
- Radiographs

Please note each patients insurance policy is different, we encourage you to contact your insurance provider to find out what your plan covers.

Signature_____**Date**_____

Jonathan Sabourin, DPM FACFAS

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Coastal Foot & Ankle . When you schedule an appointment with Dr. Sabourin 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 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective Immediately, any established patient who fails to show or call to cancel/reschedule an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged a **$25.00 fee.**

- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a **second** time will be charged a **$50.00 fee.**

- If a third No Show or call to cancellation/reschedule with no 24 hour notice should occur the patient may be **dismissed** for Coastal Foot & Ankle.

- Any new patient who fails to show for their initial visit will not be rescheduled.

- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit.**

- As a courtesy, when time allows, we make 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 Practice Manager, Stephanie, who may be able to waive the No Show fee. You may contact our office 24 hours a day, 7 days a week. If after hours, press 1 to leave a message. Messages left at either location are acceptable.

Signature_____**Date**_____

Jonathan Sabourin, DPM FACFAS