DR. JAMES RICKETTI, D.P.M. DR. JOHN FRANCESCHINI, D.P.M.

PATIENT # **TODAY'S DATE**

PATIENT INFORMATION SHEET
(PLEASE COMPLETE ALL APPLICABLE INFORMATION)

LAST NAME _____ FIRST NAME/MI _____
ADDRESS _____ CITY/STATE _____ ZIP _____
HOME# _____ CELL# _____ WORK# _____
DOB _____ AGE _____ GENDER _____ SOCIAL SECURITY # _____-_____-_____
EMAIL ADDRESS_____ OCCUPATION _____

MARITAL STATUS _____ STUDENT _____
EMPLOYMENT: FULL-TIME PART-TIME UNEMPLOYED
EMPLOYER _____
ADDRESS _____ CITY/STATE _____ ZIP _____

RESPONSIBLE PARTY (OF OTHER THAN PATIENT): PARENT / SPOUSE / OTHER
LAST NAME _____ FIRST NAME/MI _____
ADDRESS _____ CITY/STATE _____ ZIP _____
PHONE # _____

PRIMARY CARE PHYSICIAN _____ REFERRAL _____
ADDRESS _____ CITY/STATE _____ ZIP _____
PHONE# _____ LAST SEEN _____

PRIMARY INSURANCE (PLEASE PROVIDE INFORMATION & COPY OF CARD):
INSURANCE COMPANY NAME _____
POLICY # _____ GROUP # _____
SPECIALIST COPAY AMOUNT $_____

SUBSCRIBER (IF OTHER THAN PATIENT): PARENT / SPOUSE / OTHER
LAST NAME _____ FIRST NAME/MI _____
ADDRESS _____ CITY/STATE _____ ZIP _____
DOB _____ PHONE # _____

SECONDARY INSURANCE:
INSURANCE COMPANY NAME _____
POLICY # _____ GROUP # _____
SPECIALIST COPAY AMOUNT $_____

SUBSCRIBER (IF OTHER THAN PATIENT): PARENT / SPOUSE / OTHER
LAST NAME _____ FIRST NAME/MI _____
ADDRESS _____ CITY/STATE _____ ZIP _____
DOB _____ PHONE # _____

Is the reason for your visit due one of the following?
MOTOR VEHICLE ACCIDENT: **YES NO** WORKER'S COMP: **YES NO** OTHER LIABILITY: **YES NO**

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I (print) _____ understand the Notice of Privacy for the office. (A copy available upon request)

_____
Signature Date

I allow my Medical information to be released to:

EMERGENCY CONTACT: _____ RELATIONSHIP_____
PHONE: _____
NAME: _____ RELATIONSHIP _____
PHONE: _____
NAME: _____ RELATIONSHIP _____
PHONE: _____

PHARMACY NAME _____
STREET ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE # _____

Patient Financial Responsibility Policy

Thank you for choosing James C. Ricketti, DPM for you podiatric care needs. We are committed to providing you with the highest quality care. Every patient must be thoroughly informed of the treatment options and the financial obligation for a particular service. Please carefully read and then sign this form to acknowledge your understanding of your financial obligations related to your treatment. If you should have any questions regarding our financial policies, please ask our staff before signing this document.

The following is our payment policy, which we require you to read and sign prior to your visit(s).

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.

Patients have many different types of insurance and payment options for services rendered. Also, not all podiatrists in the practice accept the same type of insurance. To ensure that we have accurate information to process your claim, we will make a copy of your insurance identification card at the time of your appointment.

You are required to inform us immediately of any changes in demographic information or insurance information. Patients without insurance are required to pay in full at the time of service.

However, we understand that financial hardships may affect your ability to pay in full. We will always do everything we can to work with you. Please ask to speak to our Billing Coordinator, to discuss a satisfactory arrangement.

Participating Plans: You must present your insurance card and, if applicable, your insurance referral form at every visit. We will submit your medical claim directly to your insurance company for payment on your behalf. Full payment at the time of service is expected for all patients without insurance or those covered under plans which we do not participate in.

Non-Covered Services: If your provider does not participate in your insurance plan or your services are not covered by your insurance plan, you are responsible for payment of all charges at the time of service. We can submit the claim directly to your carrier, or a claim can be mailed to you.

Copayments or Deductibles: If your doctor waives your copayment or deductible, he/she is in effect giving you a discount. Therefore, if he/she is willing to provide this service to you at a discount, he/she must disclose this to your insurer and give the same discount to them. **All copays, deductibles, and non-covered services will be collected at the time of service.**

Cancellations and Missed Appointments: Our policy is to charge for missed appointments not cancelled at least 24 hours prior. These charges will be your responsibility and billed directly to you.

Returned Checks: Any returned checks will incur a service charge of $25.00.

Nonpayment: If your account is over 30 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During those 30 days, we will only be able to treat you on an emergency basis.

Collection Fees: In the event my account is placed in collection status, any fee incurred due to this will be added to my outstanding balance. These charges will be your responsibility and billed directly to you.

Payment: For your convenience, the following payments methods are accepted: cash, personal check, Visa, MasterCard, American Express, and Discover. There is a 2% surcharge charge added to all credit card/debit card payments. There is no service charge for HSA or FSA.

I authorize payments to be made directly to James C. Ricketti, DPM and fully understand that I am the responsible party for all charges incurred by me or my dependents at this facility. I also authorize the release of any and all information required to collect and process my medical insurance claims. I have read the "Financial Policy"; I understand and agree with it. By my signature below, I hereby authorize the assignment of financial benefits directly to James C. Ricketti, DPM for services rendered as allowable under standard third -party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Policy:

_____

Print Name of Patient or Responsible Party

_____

Signature of Patient or Responsible Party

Today's Date: _____