

OCEAN STATE FOOT & ANKLE SPECIALISTS

Arun S. Karwal,DPM

Shaylyn K. McTeague,DPM

Erik M. Haniuk,DPM

PATIENT INFORMATION

Patient name _____ Today's Date _____
Social security # _____ - _____ - _____ Date of birth _____ Age _____
Home address _____ City _____ State _____ Zip _____
School address _____ City _____ State _____ Zip _____
Home phone (____) _____ - _____ Work phone (____) _____ - _____ Male _____ Female _____
Cell phone/ pager (____) _____ - _____ Email address _____
Employer _____ Occupation _____
Employer's address _____ City _____ State _____ Zip _____
Emergency contact _____ Relationship _____ Phone _____
May we talk to this person regarding your medical concerns if we cannot reach you? Y / N
Primary care Physician _____ Phone _____ Last seen _____
Whom may we thank for referring you to our office _____
Pharmacy _____ Address _____ Phone (____) _____ - _____

INSURANCE INFORMATION

Primary insurance _____ Policy # _____
Name of policy holder _____ Relationship to patient _____
Policy holder's date of birth _____ Holder's address _____
Policy holder's employer _____

Secondary insurance _____ Policy # _____
Name of policy holder _____ Relationship to patient _____
Policy holder's date of birth _____ Holder's address _____
Policy holder's employer _____

Is this a Worker's Compensation injury? YES _____ NO _____ Date of the injury _____
Did the injury occur at work? YES _____ NO _____ Place of injury _____
Contact person (Adjuster) _____ Claim # _____
Name and address to be billed _____

Describe your foot problem _____

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

I authorize the release of any medical or other information to any healthcare professional, or if necessary to process my medical billing claims. I also authorize payment of medical benefits to the above named physicians for services rendered to me by them.

Signature of Patient Date

Signature of Guardian Date

Health History: Do you have, or have you ever had any of the following health Problems?

	YES	NO		YES	NO
Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/paralysis.....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis/blood clots.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/ gout.....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach trouble/ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems/ murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/lung disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Previous heart attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/tumor.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Nervous/emotional disorder.....	<input type="checkbox"/>	<input type="checkbox"/>

List any other current medical conditions you may have _____

Please list all current medications/vitamins and supplements that you are taking and their frequency.

Please list all medication allergies and your reaction. (example-penicillin/hives and itching)

Please list all hospitalizations and surgeries. _____

Please list any family history of chronic diseases/problems. (example-diabetes/father, ankle arthritis/uncle) _____

Social History:

Do you smoke? ☐ YES ☐ NO If yes, how many packs of cigarettes per day? ____ # of years ____

Do you drink alcoholic beverages? ☐ No ☐ Rarely ☐ Social ☐ Daily ☐ Heavy

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

Single ____ Married ____ Widow ____ Number of children ____ Height ____ Weight ____ Shoe size ____

Review of Systems: Do you have or have you had . . .

	YES	NO		YES	NO
Weight change in the last year	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Serious problems with eyes/ears	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/abdominal pains	<input type="checkbox"/>	<input type="checkbox"/>
Swollen glands/unusual lumps	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Racing heart/skipping beats	<input type="checkbox"/>	<input type="checkbox"/>	Frequent constipation/diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain/tightness	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
Ankle/leg swelling	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/tiredness	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol problems	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain/swelling	<input type="checkbox"/>	<input type="checkbox"/>
Frequent cough/wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>	Fractured/ broken bones	<input type="checkbox"/>	<input type="checkbox"/>
Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV (AIDS) concerns	<input type="checkbox"/>	<input type="checkbox"/>

**Ocean State
Foot & Ankle
Specialists**



**Arun S. Karwal
Shaylyn K. McTeague
Erik M. Haniuk**

Patient name _____ Date of birth _____

MISSED APPOINTMENT POLICY

We want to thank you for choosing us as your health care provider. In order to give you and all our patients, the best possible care, we request that you review our policy regarding missed appointments. A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 24-hours. Please remember that we have reserved appointment times especially for you. Therefore, we request at least a 24-hour notice in order to reschedule your appointment. This will enable us to offer your canceled time to other patients.

If you are unable to keep your scheduled appointment time, please call our office at least 24-hours in advance in order to avoid a missed appointment fee. This charge is not covered by insurance. Your phone call is critical in helping us provide continuous care to all of our valued patients.

If you fail to give us notice of your missed appointment, you will be charged a \$25 missed appointment fee.

I have read and understand the policy stated above:

Signature _____

Date _____

20 Cumberland Hill Road, Suite 210
Woonsocket, RI 02895
Phone:(401)356-4262
Fax:(401)356-4369

Patient name _____ Date of birth _____

Ocean State Foot & Ankle Specialists

Patient Financial Agreement

Our staff is happy to work with you to help answer questions you may have about the services we offer and how payment is handled. Please note, however, that some issues can only be addressed between you and your insurance provider(s). This document explains some common responsibilities you may have as a patient; please take a moment to review it and let us know if you have any questions or comments.

PATIENT RESPONSIBILITIES

- You are responsible with providing us with **accurate billing** information for each family member at the time of service.
- If your insurance company requires you to choose a Primary Care Physician (PCP), it is your responsibility prior to your visit to ensure that you have **authorization** for your visit with us.
- Our billing staff is available to provide you with assistance, but cannot resolve disputes between you and your insurance company.
- If your insurance company requires a referral, it is your responsibility to obtain this from your Primary Care Physician **prior** to your visit to our office.

COPAYMENTS

- **Your insurance company requires you to pay your copay at the time of each visit. These will be collected prior to your visit.**
- Your copay may be made with cash, check, Credit Card, or Debit Card.
- If your check is returned, a \$25.00 returned check fee will be assessed. After two subsequent returned checks, you will be required to pay by cash or credit card only.
- If you do not have insurance coverage at the time of your visit, you will have considered a "self pay" patient with payment due at time of service.
- Our billing department will send out billing statements for outstanding balances. **If your balance is unpaid after two billing statements, your account will be automatically sent to a collection agency.** It is the policy of our collection agency to report delinquent accounts to credit bureaus.

DEDUCTIBLES

- **It is your responsibility to understand any deductibles that may apply to you under your Insurance Policy.**
- Our billing department will send you a statement of the amount your insurance company has determined is applied to your deductible and is owed by you.

INSURANCE INFORMATION

- It is your responsibility to ensure that we have accurate insurance information. If an insurance claim is rejected as a result of incorrect information you provided, you are responsible for full payment.
- Ocean State Foot & Ankle Specialists will submit claims to your insurance carrier on your behalf. You give us permission to provide your insurer(s) with any information necessary for payment. You give us permission to ask your insurer to pay us directly for care we provide.
- If you have multiple insurance policies, you must inform us of each and every policy. It is your responsibility to know which insurer is primary and to inform us of this.

INSURANCE COVERAGE

- **Medical insurance does not always cover the entire cost of your medical care.** If we believe a service we are offering you may not be covered by your insurance, we will tell you. In some instances, however, we do not learn that a service is not covered until after we submit a bill. You are responsible for payment if your insurance company refuses to pay for a service.

DURABLE MEDICAL GOODS

- These include but are not limited to Night Splints, Braces, Shoe inserts, Orthotics, Air Braces, Diabetic shoes and ankle supports. These goods may not be covered either partially or in full by your carrier. In the event these goods are not covered, you will be expected to pay the balance at the time of visit or immediately upon receipt of billing.

HOME ADDRESS AND TELEPHONE

- You will be asked to complete a patient registration form that asks for important information about you. Please complete this form to the best of your knowledge, and keep us informed of any changes on subsequent visits.
- It is important that we have accurate information on the guarantor. This is the person who is financially responsible for your bills.

SPECIAL CIRCUMSTANCES

- We may accommodate special arrangements for payments in extenuating circumstances upon request. Please note that this is at our discretion. If special arrangements are made for divided payment, prompt reimbursement will be expected on the arranged schedule, and missed payments will be handled as any other delinquent payment as described above.

Please sign, to signify that you understand the information contained in this Financial Agreement.

Signature _____

Patient name: _____ Date of birth: _____

OCEAN STATE FOOT AND ANKLE SPECIALISTS

SMS CONSENT

By signing below, I am providing Ocean State Foot and Ankle Specialists consent to receive automated text and voice messaging to the phone number provided. Mgs and data rates may apply. A patient can opt out of SMS text or voice messaging at any time by replying "STOP" to the text or voice message. If the patient opts out, it will disable the specific option and show a lock icon with the text, "Patient declined reminder type," indicating the patient has opted out of SMS text and/or voice messaging.

Signature: _____

Date: _____

Arun S. Karwal

Shaylyn K. McTeague

Erik M. Haniuk

Ocean State Foot and Ankle Specialists

AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTION

5. Give permission for my physician to obtain information about my utilization of medications from other physicians any pharmacy and the drug enforcement agency
6. I understand that state law prohibits driving and operation of dangerous equipment while taking any sedating medication, even if I do not feel sedated.
7. **Postoperative medication guideline:** The expectation is to be completed with pain medication 1-2 weeks after surgery if more medication is needed the amount will be reduced to each prescription refilled thereafter.
8. I understand that a copy of this agreement will be provided to me at my request.

By my signature below, I knowlege that I have read and understand this agreement and agreed to abide by its terms.

_____ x _____ / /

Patient Name

Patient signature

Date

Ocean State Foot and Ankle Specialists

Dr. Arun S. Karwal
Dr. Shaylyn K. McTeague
Dr. Erik M. Haniuk

AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTION

The purpose of this agreement is to prevent misunderstanding about certain medicines you will be taking for pain management. This is helpful to you and your physician to comply with the law regarding controlled medications.

Controlled substance medications (i.e., opioids, tranquilizers) are very useful but have the potential for misuse and addiction and are closely controlled by the state and federal government. Because my physician is prescribing such medication for me to help manage my condition, I agreed to the following conditions:

1. **I am responsible for my controlled substance medication.** If the prescription or medication is lost, or if I use/finish the prescription sooner than was prescribed it I understand that it **WILL NOT** be replaced. If the prescription is stolen I must provide a police report and come in for an appointment before the medication **MAY** be replaced. If I will be out of town during my regular refill date, I will provide my physician with a printout of my itinerary from the airline, travel agent, hotel or other appropriate entity before an early prescription **MAY** be given.
2. If I receive a prescription for controlled medication from another doctor, I will notify my physician within 24 hours.
3. Refills of controlled substance medication
 - a. **WILL NOT BE MADE AS AN EMERGENCY.** I will call at least seventy-two (72) hours head of the refill date if I need assistance with controlled substance medication prescription.
 - b. **Will be made only during my physician's regular office hours.** Refills will not be made at night, weekends, or on holidays
 - c. Will only be made if all appointments are kept and have been seen regularly to monitor the effect in the usage of the medication
 - d. Will only be made for the acute phase of pain management, if I am currently on long term opioid therapy or opioid abuse therapy (i.e., methadone/suboxone) I will coordinate with my original physician for restarting long term pain medication therapy or opioid abuse therapy after the acute phase of prescribing is complete.
4. Understand that if my pain management is not controlled when reducing the medications, I will seek a referral to pain management clinic.