Dr. Michael di Gregorio
13301 N Meridian Ave, #701
Oklahoma City, OK 73120
(405) 751-6152

Meridian Family Foot & Ankle Clinic

Name (Last)_____ (First) _____ (MI) _____

SSN _____ Date of Birth ___/___/_____ Age _____Sex _____

Home Address _____ Marital Status _____

City, State, Zip _____

Phone # (Home) _____ (Work) _____ (Cell) _____

Employer _____ Occupation _____

Race _____ Language_____ Height_____ Weight_____ Shoe Size_____

Email _____ Primary Physician _____

Pharmacy Name/Phone _____

Emergency Contact Info

Name_____Phone#_____Relationship_____

How did you hear about us? _____

Name of Insured (if other than self) _____ Date of Birth ___/___/_____

Insured's Employer _____ Insured's Phone# _____

Patient is: ☐ Subscriber ☐ Spouse ☐ Dependent ☐ Other

Person responsible for paying the bill (The Guarantor) ☐ Patient is Guarantor ☐ Insured is Guarantor

Name_____Phone # _____

CONSENT

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

Signature_____ Date_____

If signing for a minor, please list your relationship to patient:_____

MEDICAL HISTORY

Meridian Family Foot & Ankle Clinic

What is your complaint today?_____

_____

How long has it been bothering you_____

If applicable, what was the date of your injury? _____ Side/Site: Right ☐ Left ☐

Is it possible that you could be pregnant? Yes ☐ No ☐

MEDICAL HISTORY (Check all that apply)

☐ Aids/HIV	☐ Foot/leg Cramps	☐ High blood pressure	☐ Thyroid Problems
☐ Anemia	☐ Foot Swelling	☐ High Cholesterol	☐ Tuberculosis
☐ Arthritis	☐ Ankle Swelling	☐ Kidney Disease	☐ Valve Replacement
☐ Asthma	☐ GERD	☐ Liver Disease	☐ Joint Replacement
☐ Cancer	☐ Gout	☐ Phlebitis	☐ Varicose Veins
☐ Diabetes	☐ Heart Disease	☐ Stroke	Other: _____
☐ Epilepsy	☐ Hepatitis	☐ Stomach Ulcers	Other: _____

SURGICAL HISTORY (Procedure and Year)

_____ _____

_____ _____

FAMILY HISTORY: Diabetes ☐ Cancer ☐ Heart Disease ☐ Other: _____

SOCIAL HISTORY

Nicotine use: Y ☐ N ☐ Previous: Y ☐ N ☐ Alcohol: Y ☐ N ☐ Recreational Drugs Y ☐ N ☐

If yes to nicotine use, for how long? _____ When did you quit? _____

ALLERGIES: List all allergies below **-OR-** ☐ Check if you have NO known drug allergies.

A = True Allergy **S** = Sensitivity

☐ Adhesive Tape	☐ Local Anesthetics	Pain Meds:_____
☐ Iodine	☐ Penicillin	_____
☐ Latex	☐ Sulfa Drugs	Other:_____

CURRENT MEDICATIONS **-OR-** Please Check if you have attached a list: ☐

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Signature _____ Date _____

NAIL CARE

IF you ARE Diabetic with PVD and Neuropathy:
A portion of your evaluation and treatment will be covered, depending on your insurance plan.

IF you ARE NOT Diabetic, but you have PVD and Neuropathy:
A portion of your evaluation and treatment will be covered, depending on your insurance plan.

IF you have not seen your Primary Care Physician in the last 6 months, or you are too healthy to qualify for routine foot care (per Medicare guidelines):
Evaluation and office visit will be billed to your insurance, and you will be charged a $45.00 self pay rate for routine foot care.

(It is patient responsibility to know whether or not deductible has been met and which services are covered by their insurance.)

Patient Signature:_____ Date:_____

Meridian Family Foot and Ankle Clinic, PLLC.

PATIENT BILLING POLICY

YOU are responsible for:

- Knowing what services are covered by your insurance carrier.
- Obtaining necessary referrals from your primary care physician.
- Knowing that Meridian Family Foot and Ankle Clinic, PLLC, cannot honor a request from a patient to alter or change information on an insurance claim for the claim to be processed or paid.
- Knowing that you are ultimately responsible for all charges.
- Presenting your insurance card(s) to the receptionist at every visit.
- Knowing where you can go for laboratory services as referred by your primary care doctor.
- Knowing what services are not covered by your insurance carrier. Typically school, camp, employment or drivers physicals are not covered.
- The payment for services rendered to dependent children.

PAYING your bill:

- If you do not have insurance, you must pay at the time of service.
- If Meridian Family Foot and Ankle Clinic, PLLC, has not received payment from your insurance carrier(s) within 90 days, you are expected to pay the balance in full.
- If you do not receive an Explanation of Benefits from your insurance carrier within 45 days, please contact your carrier.
- Meridian Family Foot and Ankle Clinic, PLLC, bills your insurance carrier(s) as a courtesy.
- Overpayments in excess of $25.00 will be refunded within 30 days of your request.
- The following payments are due on the date of service: Co-Payments, Deductibles, Charges for Non-Covered Services and Outstanding Debt.
- **Meridian Family Foot and Ankle Clinic, PLLC, accepts: Cash, Checks, major credit and debit cards.**
- The Clinic generates bills on a monthly basis.

FAILURE to pay your bill may result in:

- $20.00 service charge on returned checks
- $5.00 service charge for failure to pay your Co-Payment.
- Your account being taken to small claims.
- A bad credit rating
- Your account being turned over to a collection agency.
- Interest being charged as allowed by Oklahoma State Law of up to 18% per year.

Please be advised that you will be responsible for all fees that will apply if your bill is sent to a debt recovery service or attorney. Meridian Family Foot and Ankle Clinic, PLLC, agrees to work with each patient to resolve outstanding patient balances. We **offer payment plans** to those who qualify. Please contact the office to make these arrangements.

Patient Name: _____ Patient Signature: _____

Patient Date of Birth: _____ Today's Date: _____

MERIDIAN FAMILY FOOT & ANKLE CLINIC
13301 N.Meridian Ave Suite 701
Oklahoma City, Ok 73120
405-751-6152

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disdosed and how you can get access to this information, please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentially of your medical inlormation, and this practice is required by law to maintain the privacy of that protected health Information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect and to provide notice of it legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact tha Privacy Officer at this practice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We will use and disclose your protected health Information about you for treatment, payment, and healthcare operations. Following are examples of the type 9f uses and disclosures of your protected healthcare inlormation that may occur.

TREATMENT: We may use medical Information about you to provide you with medical treatment or services. Example: in treating you for a specific condition, we may need to know if you have allergies that could influence which medication we prescribe for treatment process.

FOR PAYMENT We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an Insurance company or third party. Example; We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

FOR HEALTH CARE OPERATIONS: We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical Information to review our treatment and services and evaluate the performance of your staff in caring for you.

OTHER USES OR DISCLOSURES THAT CAN BE MADE WITHOUT CONSENT OR AUTHORIZATION

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional Institution or taw enforcemsnt official
- As required by th-e US Food and Drug Administration (FDA)
- Other healthcare providers treatment activities
- Other covered entities and providers' payment acnvltles
- Other covered entitles healthcare operations activities (to the extent permitted under HIPPA)
- Uses and disclosures required by law
- Uses and disclosures In domestic violence or neglect situations
- Health oversight activities
- Other public health activities

Ws may contact your to provide appointment reminders or Information about treatment alternatives or other health related benefits and services that may be of interest 10 you

Meridian Family Foot & Ankle Clinic

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read, if so I chose) and understand the Notice. The Notice is available in its entirety at your request.

_____

Patient Name (Please Print)

_____

Parent or Authorized Representative (If applicable)

_____

Name of Third Party To Whom You Grant Access To Your Records

_____

Signature and Today's Date