T.M.POKABLA DPM LLC

Dr. Scott M. Billy, DPM

248 Niles-Cortland Rd NE

Warren, Ohio 44484

NEW PATIENTS ONLY

Please be aware this practice will only allow 2 missed initial consult new patient appointments in a year. If you miss the second scheduled appointment, you will not be rescheduled.

Rescheduled appointments with a 24 hour notice given, when rescheduling or cancelling, do not fall underneath this policy.

Make sure you have these items ready :

Your current ID- required for appointment

Your current insurance card/s (if applicable)- required for appointment

Specialist Co-pays (ready and with you) are due at time of visit.

Paperwork from the website is filled out or come at least 20 minutes earlier than your scheduled appointment time to fill them out.

SCOTT M. BILLY, DPM
248 Niles Cortland RD NE
Warren, OH 44484-1938
330-856-1700 phone

PATIENT INFORMATION:

Patient Name:_____ **DOB:**_____ **Age:**_____

SS#_____ **Email:**_____

Birth Sex: _____ **Preferred Name/Nickname:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Primary #:_____ **Secondary #:**_____ **Appointment Confirmation #:**_____

Marital Status: Single Married Divorced Widowed Separated **Spouse's Name:**_____

Race: African American American Indian Asian White Hispanic Native Hawaiian Other

Primary Care Provider:_____ **Phone:**_____

Preferred Pharmacy:_____ **Phone:**_____ **Zip Code:**_____

How did you hear about our office?:_____

Emergency Contact:_____ **Relationship:**_____ **Phone:**_____

Primary Insurance:_____ **Subscriber:**_____ **DOB:**_____

Secondary Insurance:_____ **Subscriber:**_____ **DOB:**_____

Patient's Employer:_____ **Phone:**_____

Occupation:_____

Responsible Party's Employer:_____ **Phone:**_____

Responsible Party's Address:_____

I hereby authorize T M POKABLA DPM LLC (Dr. Billy) to apply for benefits on my behalf for services rendered by Dr. Billy or by his order. I request payment from my insurance company to be made directly to T M POKABLA DPM LLC. I certify that the insurance information reported is correct. I acknowledge that **I AM RESPONSIBLE FOR COPAYS, DEDUCTIBLES AND REQUESTING A REFERRAL (if required by my insurance)** from my primary care provider. If my insurance does not cover cost of any services, I agree to be fully responsible for them. If I default on any payment, I will be responsible for any collection costs including, but not limited to: collection agency fees, court costs and reasonable attorney fees incurred to collect this debt. I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original.

I HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE.

Signature:_____ **Date:**_____

(Patient, Parent or Guardian)

Please be aware that if I FAIL to give 24 hours notice when canceling or rescheduling my appointment that my account will be charged $25.00 without notification (extenuating circumstances do apply).

I acknowledge that a copy of the Notice of Privacy Practices is available to me if I should wish to obtain one. I have read (or had the opportunity to read if I so choose) and understand the Notice.

Signature:_____ Date:_____

(Patient, Parent or Guardian)

REASON FOR VISIT: _____

How long ago did the problem start?: _____ Days / Weeks / Months / Years **(*If injury please skip and see below)**

Was there an injury?:(Describe)_____

Was the injury work related?: ☐ Yes ☐ No

*Date of injury:_____

Did your pain or problem: ☐ Began all of a sudden ☐ Gradually develop over time

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing

☐ Other:_____

How would you rate your pain on a scale from 0 to 10?: (Please Circle)
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

Since the time your pain/problem began, has it: ☐ Stayed the same ☐ Become worse ☐ Improved

What makes it worse?:_____

What makes it better?:_____

Athletic Activity:_____

How much time each day are you on your feet?:_____ hrs

Height: _____ft _____in Weight: _____ lbs Shoe Size:_____

SOCIAL HISTORY:

Tobacco Use: Yes No Packs/Day:_____ # of Years:_____ Year Quit:_____
Alcohol Use: Yes No Drinks/Week:_____
Illicit Drug Use: Yes No Type:_____ # of Years:_____ In Recovery: Yes No

PAST MEDICAL HISTORY: (* Please Describe on line listed below)
☐ **IF YOU BROUGHT A LIST, YOU MAY SKIP THIS SECTION.**

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anesthesia Complications*
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots*
- ☐ Bronchitis
- ☐ Cancer*
- ☐ Cerebral Palsy
- ☐ Chest Pain
- ☐ Circulation Problems*
- ☐ COPD/Emphysema
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Falls
- ☐ Fibromyalgia
- ☐ Gout
- ☐ GERD/Heartburn
- ☐ Heart Disease
- ☐ Hepatitis A/B/C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Multiple Sclerosis
- ☐ Numbness in Feet
- ☐ Polio
- ☐ Rheumatoid Arthritis
- ☐ Sexually Transmitted Infections
- ☐ Shortness of Breath
- ☐ Sickle Cell Anemia
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Swelling of legs
- ☐ Thyroid Disease
- ☐ Toes Turn Blue In Cold
- ☐ Tuberculosis
- ☐ Ulcerative Colitis
- ☐ Varicose Veins
- ☐ Weight Loss/Gain*
- ☐ Wound Healing Problems

Other Medical Problems:

_____

_____

*Describe:_____

MEDICATIONS: (Please include all prescriptions, over-the-counter, and vitamins with dosage; if possible please provide a detailed list)

☐ **IF YOU BROUGHT A LIST, YOU MAY SKIP THIS SECTION.**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES: (For each allergy please list reaction on lines below)

☐ **IF YOU BROUGHT A LIST, YOU MAY SKIP THIS SECTION.**

- ☐ No Known Allergies
- ☐ Adhesives
- ☐ Anesthetics
- ☐ Aspirin
- ☐ Codeine
- ☐ Eggs
- ☐ Iodine
- ☐ Latex
- ☐ Nickel
- ☐ Penicillin
- ☐ Sulfa
- ☐ Seasonal
- ☐ Tetracycline

Other:_____

Reactions:_____

SURGICAL HISTORY: (* Please be specific)

☐ **IF YOU BROUGHT A LIST, YOU MAY SKIP THIS SECTION.**

- ☐ Appendix
- ☐ Arthroscopy
- ☐ Cancer*
- ☐ Carpal Tunnel
- ☐ Cesarean Section
- ☐ Elbow
- ☐ Gallbladder
- ☐ Heart*
- ☐ Hip*
- ☐ Hysterectomy
- ☐ Knee*
- ☐ Ovary
- ☐ Shoulder*
- ☐ Tonsils
- ☐ Vascular Surgery*

Other:_____

Previous Foot Surgery:_____

HOSPITALIZATIONS: (Please state when you were admitted to the hospital overnight and the reason for the hospitalization)

☐ **IF YOU BROUGHT A LIST, YOU MAY SKIP THIS SECTION.**

_____

_____

FAMILY HISTORY:

- ☐ Rheumatoid Arthritis
- ☐ Cancer
- ☐ Blood Clots
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Stroke

Patient's Signature: _____ Date: ____ / ____ / _____

(Or Responsible Party)

I Have Reviewed this Medical History

Doctor's Signature (Scott Billy, DPM): _____ Date: ____ / ____ / _____

RECORD OF DISCLOSURES

In general, the HIPAA privacy protects patients from anyone that is not authorized to access your protected health information (PHI), without your consent. It gives individuals the right to request a restriction on uses and disclosures of their PHI.

Below is a list who I authorize that the office of

T.M.Pokabla, DPM LLC – Dr. Scott M. Billy, DPM

can discuss my Protected Health Information with including appointment cancellations and changes:

NAME	RELATIONSHIP	PHONE #
_____	_____	_____
_____	_____	_____
_____	_____	_____

*****FOR APPOINTMENT CHANGES AND CANCELLATIONS ONLY*****

Below is a list of authorized individuals who may cancel and reschedule my appointments on my behalf ONLY. ****They will not have access to my protected health information

NAME	RELATIONSHIP	PHONE #
_____	_____	_____
_____	_____	_____
_____	_____	_____

****If an individual is not listed above (IN EITHER TOP TWO SECTIONS), a cancellation or rescheduling request will not be allowed/accepted.****

PATIENT SIGNATURE _____

PATIENT PRINTED NAME AND DATE OF BIRTH_____

DATE_____

T.M. Pokabla, D.P.M., L.L.C
Scott M. Billy, D.P.M.
248 Niles-Cortland Rd, N.E.
Warren, Ohio 44484-1938

PODIATRIST

330-856-1700

NO-SHOW POSTED POLICY ACKNOWLEDEMENT

This is an acknowledgment that you have read and understood our basic no-show policy. **This is not an agreement**, but an acknowledgement that you have been informed of how our no-show policy works and which circumstances with which you will be charged. We know some things are unavoidable, and we will look at these on a case by case basis and apply only to EXTREME CIRCUMSTANCES. This is a posted policy in every room and at check out and check in.

Posted Policy-
You will be charged a $25 No-Show fee if you:

1. Don't give 24 hours notice when canceling or rescheduling appointments- MAKE SURE TO CALL THE OFFICE DURING REGULAR BUISNESS HOURS, BEFORE WE CLOSE, THE DAY BEFORE ESPECIALLY ON FRIDAY FOR MONDAY APPOINTMENTS.

2. Call the day of your appointment to cancel or reschedule

3. You don't have your co-pay at the time of visit resulting in having to reschedule your appointment. We inform all patients, and it is posted that co-pays are due before being seen and this is across the board for all patients.

4. IF YOU ARE MORE THAN 15 MINUTES LATE FOR YOUR SCHEDULED APPOINTMENT, YOU WILL BE SEEN ON THAT SAME DAY BY THE DOCTOR, **WHEN THE SCHEDULE ALLOWS**. THIS MEANS THERE COULD BE AN **EXTENDED WAIT** TO BE SEEN. If YOU CHOOSE not to wait you can choose to reschedule your appointment and you will be charged a $25 no-show fee.

★Any appointment that is scheduled that requires a half an hour or longer will be subject to a fee schedule. The first (1) missed appointment will be **$25**, the second (2) missed appointment will be **$50**, and the third (3) missed appointment will be **$50**. If you miss the fourth (4) scheduled appointment, you will be discharged. Our office staff will always inform you if your scheduled appointment falls into this time category, when scheduling your appt.★
NEW PATIENTS THAT ARE BEING SEEN FOR INITIAL VISITS AND ARE 15 MINUTES LATE WILL BE RESCHEDULED

There has been a tremendous increase in missed appointments lately. Our goal is to accommodate all patients needing to see the doctor, but a pattern of recurrent missed appointments prevents others from being able to see the doctor in a timely manner. Thank you for your understanding on this matter.
**FEE IS DUE BEFORE YOU ARE SEEN ON YOUR NEXT SCHEDULED APPOINTMENT AND IF NOT PAID WE RESERVE THE RIGHT TO DISCHARGE YOU AS A PATIENT- **Rule 4731-27-02 Ohio Administrative Code/4731 Chapter 4731-27 **

WE DO CALL TO CONFIRM AND LEAVE VOICEMAILS (IF VOICEMAIL BOXES ARE AVAILABLE AND NOT FULL) THE DAY BEFORE YOUR APPOINTMENT AND THESE ARE ALWAYS DONE BEFORE NOON. THIS IS DONE TO GIVE YOU PLENTY OF TIME TO CALL AND RESCHEDULE OR CANCEL IF NEEDED. PLEASE CONFIRM YOU UNDERTSTAND THE ANSWERING SERVICE IS FOR AFTER HOURS EMERGENCIES ONLY AND WILL NOT TAKE APPOINTMENT CANCELATIONS. Rescheduling and canceling appointments must be done through the office during regular business hours. Monday 9am-5:30pm and Tuesday thru Friday 9am–4:45pm.

Medicaid Patients Only- This Practice Strictly Adheres to Rule 5160-1-31.1 Ohio Administrative Code/5160/Chapter 5160-1 which prohibits any medical practice from collecting any form of no-show compensation. Due to this restrictive Administrative Code, we only allow three no-shows within a year and will discharge on the fourth no-show Rule 4731-27-02 Ohio Administrative Code/4731 Chapter 4731-27.

PATIENT SIGNATURE X_____ DATE_____