Seacoast Foot Surgery Associates

Dr. James P. Wilton FACFAS, FASPS

CONSENT TO USE AND DISCLOSURE OR PROTECTED HEALTH INFORMATION (PHI)

My PHI which is the subject of this consent includes demographic information, Information about my physical or mental health condition, or condition, information about medical services provided to me, including payment information may be used to identify me. I understand, furthermore that the element of this consent are **required by state and federal law for my protection** and to ensure my informed consent to the use and disclosure and PHI necessary to support my relationship with **Seacoast Foot Surgery Associates.**

I consent to **Seacoast Foot Surgery Associates**

- Use and disclosure of my protected health information (PHI) in support of my diagnosis and treatment, payment for the medical services I receive, and the legitimate health care operations of the medical practice.
- Disclosure of PHI to other health care practitioners and facilities that are involved in providing medical services to me, my family and friends that who are providing me with emotional support as I receive my medical services.
- Disclosure of PHI to my health insurance carrier, utilization review organization, or third party administrator to support payment for my medical services.

I understand that **Seacoast Foot Surgery Associates**

- Agrees to provide medical services to me are conditional upon signing of this consent.
- Requests my consent to ensure that **Seacoast Foot Surgery Associates**. Can properly carry out the professional responsibility of caring for me.
- Will disclose only the minimum amount of my health care information which is necessary, in the judgment of **Seacoast Foot Surgery Associates** for the legitimate needs of the recipient or for my general well being.
- Regards the safeguarding of PHI as an important duty.

I understand that I have the right to:

- Restrict **Seacoast Foot Surgery Associates** use and discloser of my PHI and that **Seacoast Foot Surgery Associates** is not obligated to the requested restriction, but that an agreement to a restriction binds **Seacoast Foot Surgery Associates.**
- Revoke this consent at any time providing **Seacoast Foot Surgery Associates** with written, signed, and dated request expect to the extent that **Seacoast Foot Surgery Associates** has acted in the reliance upon my consent. However, I understand that any restrictions on the use and disclosure of PHI revocation of this consent may result in improper diagnosis or treatment, denial of coverage of a claim for insurance benefits, or other adverse consequences.

Name: ______________________________ Date: ________________

DR. JAMES P. WILTON FACFAS, FASPS
SEACOAST FOOT SURGERY ASSOC.
330 BORTHWICK AVENUE, SUITE 112
PORTSMOUTH, NH 03801

PATIENT REGISTRATION

Last Name: ____________________ First Name: ____________________ M.I./Sr./Jr. __________

Mailing Address: ____________________ City: __________ State: __________ Zip Code: __________

Phone Number: ______________ Cell Number: ______________ Email: ______________

Social Security #: ______________ Male/Female: ______________ Birth Date: ______________

Martial Status (Married/Single/Other): _____ Employed (Yes/No): _____ Student (Yes/No): _____

Responsible Party (Parent/Power of Attorney):

Last Name: ____________________ First Name: ____________________ M.I./Sr./Jr. __________

Mailing Address: ____________________ City: __________ State: __________ Zip Code: __________

Phone Number: ____________________ Date of Birth ____________________

Patient's Employer:

Name: ______________________________ Full / Part / Retired / Unemployed

Mailing Address: ____________________ City: __________ State: __________ ZipCode: __________

Phone Number: ______________________________ Extension: ______________

Doctors:

Primary Care Physician: ______________________________ Date Last Seen: __________

Referring Physician: ______________________________ Date Last Seen: __________

Insurance:

Insurance Subscriber's name (i.e. self/spouse/parent): ______________________________

Subscriber's date of birth: ______________________________

James P. Wilton DPM, FACFAS, CWS
Jackson-Gray Medical Building
330 Borthwick Avenue, Suite 112
Portsmouth, NH 03801

Medical Information

Today's date:________________ Who referred you to our office?________

Primary Care MD:_________________________

Why are you seeing the doctor today?

____

____

____

____

Allergies: **NONE** *Penicillin, Sulfa Based Drugs, Eggs, IVP Dye* Other:________________

Previous Surgeries/Hospitalizations: Year:

____ ____________

____ ____________

____ ____________

____ ____________

Examination: T: BP: R: P: HGT: WGT:

Medication	Dose	Medication	Dose

Review of Systems-Have you ever in the past had problems with (circle all that apply)?

General-fevers, chills, anorexia, fatigue, cancer, sleeping problems
Eyes-blurred vision, vision loss, eye discharge, eye pain
Ears/Nose/Throat-emphysema, earaches, ear discharge, ringing in the ears, decreased hearing, nasal congestion, nosebleeds, chronic sore throat
Cardiovascular-hypertension, angina, heart attack, heart murmurs, chest pain, heart palpitations, lightheadedness, difficulty breathing with exertion
Respiratory-chronic coughing, wheezing, asthma
Gastrointestinal-constipation, heartburn, stomach ulcerations, gastric bleeding, chronic-nausea/vomiting/diarrhea/abdominal pain change in bowel habits, jaundice
Musculoskeletal-chronic limb pain, low back pain, neck pain, joint pain, joint swelling, muscle cramps, muscle weakness, stiffness, arthritis
Skin-skin rashes, itching, dryness, suspicious skin lesions
Neurologic-transient or permanent paralysis, muscle weakness, nerve pain in the limbs, seizures, tremors, loss of balance, sciatic nerve pain
Psychiatric-depression, anxiety, suicidal ideation, hallucinations, paranoia, addiction
Endocrine-diabetes, thyroid disease, cold intolerance, heat intolerance, significant weight gain or loss
Hematologic/lymphatic-abnormal bruising, prolonged bleeding, enlarged lymph nodes
Allergic/Immunologic-hay fever, chronic itching, persistent infections, HIV exposure, hepatitis

Family History

Member	Alive	Deceased	Health Status/ Cause of Death
Father	A	D	
Mother	A	D	
Sister/ Brother	A	D	
Sister/ Brother	A	D	
Sister/ Brother	A	D	
Grandparents (Mom)	A	D	
Grandparents (Dad)	A	D	

Social History

☐ Work ☐ Employed (Occupation)______________________ ☐ Student ☐ Retired ☐ Disabled
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Children? ☐ No ☐ Yes #_______ Do you live alone? ☐ No ☐ Yes
Exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never What Type of exercise?____________________
History of substance/alcohol abuse? ☐ No ☐ Yes Smoke currently or previously? ☐ No ☐ Yes____ Packs per day for____Years
Drink Alcohol? ☐ No ☐ Yes

Highest level of education attained: High School---College---Graduate School

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the Doctor or a member of the office staff for assistance.

Patients Signature:______________________________ Date:______________________

Patients Name (Please Print): ____

Dr. James P. Wilton FACFAS, FASPS
Surgery and Medicine of the Foot and Ankle
Lower Extremity Nerve Surgery

ABOUT FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you with the best possible care. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. If you have medical insurance, we will gladly help you receive your maximum allowable benefits. In order to achieve these goals, we are outlining our practice policy and contractual agreement with most insurers in this geographical region:

Upon verification of coverage, we will directly bill your insurance company for ALLOWABLE services. This includes primary, as well as secondary insurers. We will bill a maximum of ***two insurers*** *on your behalf. Your insurance is a contract between you, your employer, and the insurance company. Specific questions regarding coverage for podiatric services should be addressed with your insurer. Our fees are based on "usual and customary" rates for this geographical region.*

All insurance contracts are different; some of your charges may not be covered. ***If your treatment plan with Dr. Wilton requires durable medical equipment (i.e. orthotics, inserts, padding, supplies, etc.), payment will be collected upon ordering. Most of the items are "custom-made". They are non-returnable and non-refundable. We will not bill your insurer for these items without written authorization from your insurer.*** INITIAL ________

If you have a co-payment, co-insurance, or deductible, this payment will be collected at the time of service. If you have no insurance, payment will also be collected at the time of service. If you are unable to make these payments at the time of your visit or are unprepared to do so, your appointment will be rescheduled, subject to a cancellation fee. INITIAL ______

Your insurance company provides each patient with an Explanation of Medical Benefits. This will outline your financial responsibility for medical care provided.

WE DO NOT PATIENT BILL. INITIAL ______

The office of Dr. James P. Wilton is hereby authorized to release any information to my insurance carrier necessary for the claims processing and payment of my bill. I hereby assign to the office of Dr. James P. Wilton payment of medical insurance benefits.

I understand that I am ultimately responsible for any charges incurred in the collection of any outstanding balance, including interest charges accrued after 30 days, late fees, NH Credit Bureau collection fees, and attorney fees.

Signature: ____ Date: ______________

Patient Easy Pay Consent

My insurance contract is an agreement between my insurance company and me. Per that contract, **all co-payments, coinsurance, and deductibles are collected at the time of visit.** If I am uncertain of my financial requirements as outlined by my insurance company, I will contact them directly.

I assign my insurance benefits to Seacoast Foot Surgery Associates. I understand that this form is valid for one year from my last processed date of service. Should my billing information change, I will contact this office with new, updated information. Failure to inform the office staff of changes in insurance coverage will result in all charges being directly responsible by me. Cancellation of this agreement must be made through written notice.

Please choose from one of the two options below. This form must be completed before your visit today:

1. Patient balances are described in the Explanation of Medical Benefits provided by my insurance company. Any questions regarding the processing of my claims will be handled through my insurance company by me. **Patient bills are not mailed. I authorize Seacoast Foot Surgery Associates to maintain my credit/debit card on file for any balance of charges for co-payments, coinsurance, or deductibles not paid by my insurance as directed by the insurer.** This payment will be applied to my credit card and my account **after** the insurance company has processed my explanation of medical benefits for each date of service. I understand that my credit/debit card information will be held in strictest confidentiality. INITIAL ________

Easy Pay Registration:

____

Cardholder Signature Date

____

Patient name

____

Cardholder name

____

Credit or Debit Card type/number Exp. Date (Visa; Discover or Mastercard)

2. I do not wish to leave a credit/debit card on file. A member of the office staff will contact me by telephone regarding any outstanding balance. I will give my payment information over the phone. Failure to respond to attempts to collect this balance will result in my account will be placed in collections with the NH Credit Bureau. INITIAL ________