

**FRED LOMBARDO, DPM**

DATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ MALE \_\_\_ FEMALE \_\_\_ SOCIAL SECURITY NO \_\_\_\_\_

PREFERRED LANGUAGE \_\_\_\_\_ RACE \_\_\_\_\_

SPOUSES NAME \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_ PH NO \_\_\_\_\_

REFERRED BY \_\_\_\_\_

EMPLOYER \_\_\_\_\_

EMERGENCY CONTACT/RELATIONSHIP \_\_\_\_\_

EMERGENCY CONTACT PHONE \_\_\_\_\_

PHARMACY \_\_\_\_\_ CITY \_\_\_\_\_ PH NO \_\_\_\_\_

MEDICATIONS \_\_\_\_\_

ALLERGIES \_\_\_\_\_ SURGERIES \_\_\_\_\_

FAMILY HISTORY PLEASE CIRCLE: MOTHER: HEART DISEASE / DIABETES

FATHER: HEART DISEASE / DIABETES

DO YOU SMOKE? YES \_\_\_\_\_ NO \_\_\_\_\_ FORMER SMOKER \_\_\_\_\_

DIABETIC: YES \_\_\_ NO \_\_\_

FLU SHOT: YES/NO: DATE \_\_\_\_\_ PNEUMONIA: YES/NO: DATE \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_ / \_\_\_\_\_

MEDICAL CONDITIONS: PLEASE CIRCLE: DIABETES GOUT ARTHRITIS HYPERTENSION HEART DISEASE

CANCER ASTHMA BRONCHITIS EPILEPSY GALL BLADDER HEPATITS KIDNEY DISEASE LUNG DISEASE

PNEUMONIA RHEUMATIC FEVER TUBERCULOSIS OTHER \_\_\_\_\_

REASON FOR TODAY'S VIST \_\_\_\_\_ RIGHT \_\_\_ LEFT \_\_\_ BOTH \_\_\_

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DATE \_\_\_\_\_

PATENT NAME: \_\_\_\_\_

INSURANCE INFORMATION: REFERRAL NEEDED: YES \_\_\_ NO \_\_\_ COPAY AMOUNT \_\_\_\_\_

INSURANCE: \_\_\_\_\_ POLICY NO \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_ POLICY NO \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

USING A HEALTH BENEFIT CARD: YES \_\_\_ NO \_\_\_

WORKMANS' COMPENSATION INJURY: YES \_\_\_ NO \_\_\_ DATE OF INJURY: \_\_\_\_\_

AUTHORIZATION TO LEAVE MESSAGE: I HEREBY AUTHORIZE FRED LOMBARDO, DPM TO LEAVE A MESSAGE FOR PENDING APPOINTMENTS AND/OR TESTS AT MY RESIDENCE FOR MYSELF AND/OR MY MINOR CHILD. YOU MAY NOTIFY ME OF LAB/TEST RESULTS, MATTER RELATING TO PRESCRIPTIONS, MY PHYSICIAN AND FRED LOMBARDO, DPM.

\_\_\_\_ HOME ANSWERING MACHINE/VOICEMAIL

\_\_\_\_ MOBILE PHONE

\_\_\_\_ SPOUSE/PARTNER

\_\_\_\_ EMAIL ACCOUNT

\_\_\_\_ FAMILY MEMBER PLEASE SPECIFY NAME \_\_\_\_\_

\*\*\*PATIENTS UNDER AGE OF 18 MUST BE ACCOMPANIED BY PARENT OF LEGAL GUARDIAN.

I hereby authorize payment of medical benefits to Fred Lombardo, DPM. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all of the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PLEASE PRESENT YOUR INSURANCE CARD AND VALID DRIVERS LICENSE OR PHOTO ID**

**INSURANCE CO-PAYMENTS ARE DUE AT THE TIME OF THE VISIT**

**THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW CAREFULLY**

Our commitment here at Fred Lombardo, DPM is to serve our patients with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests, it may be necessary to share information with other healthcare providers or business associates. The following are examples of instances where information may be shared: Laboratory analysis; billing and/or collection service; second opinions.

**AMENDMENTS/APPOINTMENTS**

We reserve the right to change our Notice of Privacy Practice and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of change. You may obtain a revised notice by contacting the Privacy Officer at: 576 Wyoming Ave., Kingston PA 18704, 570-283-5525. **Patients MUST contact the office 24 hours prior to cancelling an appointment. Missed appointments without 24 hour notice will incur a \$50 missed appointment fee.**

**INSURANCE BILLING PRACTICES**

If we are a participating provider, we will forward claims to your insurance company. It is the responsibility of the patient to determine if we are in network with your insurance company and to obtain a referral if required. You **MUST** have the referral with you or have sent to our office at the time services are rendered. The patient is responsible for all copays, deductibles, coinsurances and non-covered services.

**ROUTINE FOOT CARE APPTS: You must inform this office if you have seen another podiatrist with the previous 61 days. Any insurance claim denied due to frequency or factors beyond our control will become the sole responsibility of the patient.**

**ACKNOWLEDGEMENT AND CONSENT**

We are committed to obeying all federal, state and local laws and regulations regarding privacy practices. If any other uses or disclosures other than the ones listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided for by law, may revoke this written authorization at any time.

I have read and understand the above Notice **of Privacy Practices**.

**SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**PATIENT OR PARENT/LEGAL GUARDIAN**

Name(s) of those to whom you may release my medical information:

\_\_\_\_\_

## Assignment of Benefits

Fred Lombardo, DPM  
576 Wyoming Avenue  
Kingston, PA 18704  
570 283-5525

Patient: \_\_\_\_\_

I, \_\_\_\_\_, understand that services rendered to me by Fred Lombardo, DPM are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Fred Lombardo, DPM and I understand that I will be fully responsible for any outstanding balance on my account. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my copay and coinsurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of said claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Fred Lombardo, DPM within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collection process, I will be responsible for any cost incurred by the office to retrieve their monies.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Fred Lombardo, DPM to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Date: \_\_\_\_\_ Witness: \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_  
**PATIENT / OR PARENT/LEGAL GUARDIAN**