

560 Riverside Drive, A-101
 Salisbury, MD 21801
 Phone: 410-749-0121
 Fax: 410-749-6807

300 Aurora Street
 Cambridge, MD 21613
 Phone: 410-228-2305
 Fax: 410-228-8521

12417 Ocean Gateway A-6
 West Ocean City, MD
 Phone: 443-664-7253
 Fax: 443-664-7518

Kevin Thomas, D.P.M. ~ Trina P. Monis, D.P.M. ~ John Thomas, D.P.M. ~ John P. Lydon, D.P.M. ~ John Shapiro, D.P.M

FIRST _____ MI _____ LAST _____ AGE _____
 ADDRESS _____ CITY _____ ST _____ ZIP _____
 PHONE: Home _____ Work _____ Cell _____
 E-Mail address _____
 Date of Birth _____ Social Security No. _____ Gender ____ M ____ F
 Employer's Name / Address _____
 Primary Dr. _____ Phone # _____ Date Last Seen _____
 Emergency Contact _____ Relationship _____ Phone _____
 Pharmacy/Address/Phone # _____
 Who referred you to this office? _____
 Reason you are here today? _____
 How long have you had this problem / condition? _____
 Symptoms you are experiencing? _____
 Does anything make your symptoms feel better or worse? _____
 Why? _____
 Please rate your pain: At rest 1-10 _____ At worst 1-10 _____ (10 being most painful)

WHEN YOU HAVE TO GO TO THE DENTIST, DO YOU HAVE TO TAKE ANTIBIOTICS DUE TO HEART MURMUR OR ARTIFICIAL JOINTS? YES _____ NO _____

DOES ANY OF THE FOLLOWING APPLY TO YOU?

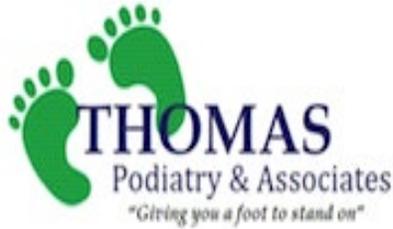
Chest Pain	YES _____ NO _____	WITH / WITHOUT EXERTION	
Shortness of Breath	YES _____ NO _____	WITH / WITHOUT EXERTION	
Coughing	YES _____ NO _____	Wheezing	YES _____ NO _____
Dizziness	YES _____ NO _____	Fainting	YES _____ NO _____
Nausea	YES _____ NO _____	Vomiting	YES _____ NO _____
Back Pain	YES _____ NO _____	Joint Pain	YES _____ NO _____
Prolonged Bleeding	YES _____ NO _____	Immune or Healing Disorders	YES _____ NO _____
Pregnant	YES _____ NO _____	Nursing	YES _____ NO _____

HAVE YOU EVER BEEN TREATED FOR?

Diabetes	YES _____ NO _____	Rheumatic Fever	YES _____ NO _____
Heart Trouble	YES _____ NO _____	Kidney Ailments	YES _____ NO _____
Asthma	YES _____ NO _____	Liver Ailments	YES _____ NO _____
COPD	YES _____ NO _____	MRSA	YES _____ NO _____
Stomach Ailments	YES _____ NO _____	Foot Ulcers	YES _____ NO _____
Gout	YES _____ NO _____	High Blood Pressure	YES _____ NO _____
Cancer	YES _____ NO _____	TYPE _____	
Tuberculosis	YES _____ NO _____		

OTHER MEDICAL PROBLEMS LISTED: _____

SIGNATURE _____ DATE _____



PATIENT _____ DOB _____

MEDICATIONS – INCLUDE DOSAGE (PILL, LIQUID, INJECTION)

MEDICATIONS YOU ARE ALLERGIC TO

MEDICATION	REACTION	MILD, MODERATE, SEVERE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SURGERY HISTORY

Procedure _____	Date _____

Do you have any artificial joints? YES NO

PLEASE LIST _____

Do you have an artificial heart valve? YES NO

SOCIAL HISTORY

Please check one: Married Single Divorced Widowed

Weight: _____ Height: _____ Shoe Size: _____ Width: _____

Do you smoke? ____ YES ____ NO How many packs per day? ____ For how long? _____

Do you drink alcohol? ____ YES ____ NO How often? _____

Substance abuse: ____ YES, I have or have had a substance abuse problem.

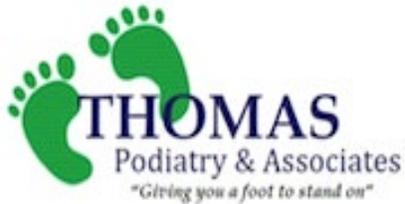
Specify _____

Are you employed? ____ YES ____ NO ____ RETIRED ____ UNEMPLOYED

What is your occupation? _____

Race _____ Ethnicity _____ Preferred Language _____

Patient Signature _____ Date _____



Name: _____ DOB: _____

Insurance Information, please complete and provide cards for scanning

PRIMARY INS CO: _____ POLICY HOLDER'S NAME: _____ DOB: _____

SECONDARY INS CO: _____ POLICY HOLDER'S NAME: _____ DOB: _____

Do you have an HSA or HRA account? [] No [] Yes Card # _____ Expiration _____

Did your foot problem result from a specific injury [] No [] Yes Injury Date ____/____/____

How did your injury occur? _____

Is this a Worker's Compensation Claim? [] No [] Yes Claim # _____

Contact: _____ Phone: _____

Authorization for Treatment/Insurance Authorization/Financial Agreement

I hereby grant authority to Dr. Kevin Thomas and Associates to administer medical treatment to my dependent minor or student family member and myself. Further, I hereby authorize my insurance carrier to pay medical and/or surgical benefits directly to Kevin Thomas D.P.M., PC. I authorize Kevin Thomas, D.P.M., PC to release any information acquired in the course of my treatment needed for medical insurance claims or consultations. A photocopy of this authorization is to be considered as valid as the original until revoked by me in writing. Participation with your insurance company requires us to collect your copay and deductible amounts. These are due at the time services are rendered, as are non-covered services. A \$10.00 fee may be added if not paid. I understand that I am financially responsible for all charges made to my account whether or not an insurance company, attorney, or other third party payer is involved with payment. I am responsible for all co-payments and co-insurance amounts, non-covered supplies and services and yearly deductibles. I agree to pay all collection expenses including a \$35.00 return check fee, attorney's fees, court costs, filing fees, including charges that may be assessed by any collection agency retained to pursue this matter. As of 6/1/2012 there **Will be a \$40.00 fee for missed appointments.** _____ Initials

I hereby give consent to Kevin Thomas, DPM, Trina P. Monis, DPM, John Thomas, DPM and or John P. Lydon, DPM to perform in office medical / surgical procedures deemed medically necessary in accordance with my individualized plan of care.

Statement of Disclosure House Bill 1280

Health Care Practitioners-Referral of Patients

Kevin Thomas, D.P.M., PC owns Riverside Ambulatory Surgery Center, LLC. If you have health care services scheduled at the above facility, please know that a valid medical need exists for this referral and that you have the option of selecting another health care facility for these services.

I acknowledge receipt of this information and the options available to me to select another health care facility should I so choose.

Privacy Information Preferences

- Can we leave voicemail on answering machine? _____ Yes _____ No
- I authorize discussion of my personal health information with the following person(s):

Name: _____ Relationship: _____ Phone: _____

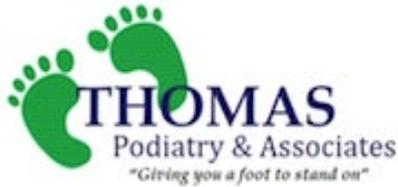
Name: _____ Relationship: _____ Phone: _____

Privacy Practice

I acknowledge that I was provided a copy of the Privacy Practice of Kevin Thomas, D.P.M., PC and Riverside Ambulatory Surgery Center, LLC. And that I have read (or had the opportunity to read if I so choose) and understood the Notice.

Today's Date ____/____/____

Signature: _____ Parent/Guardian Signature: _____



WELCOME TO OUR OFFICE: Thomas Podiatry & Associates

PLEASE ARRIVE 30 MIN. PRIOR TO YOUR APPOINTMENT TIME.

In an effort to better serve you, please fill out the entire packet of information prior to your scheduled visit.

Please complete the following items:

_____ Patient Information Sheet

_____ Insurance Authorization Form

_____ Office Policy Form

_____ Privacy Practices Acknowledgement

WE ACCEPT CASH, CHECK OR CREDIT CARDS FOR PAYMENT

Please bring your **INSURANCE CARD(S)** so that we can copy them.

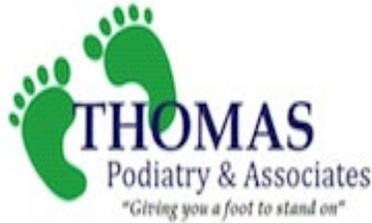
If your insurance requires you to have a referral, please obtain one from your primary care physician **PRIOR** to the date of your visit. Without the referral your insurance will not pay for the visit and you will be responsible for the charges.

Bring your **MEDICATIONS** with you or a list of the medications you are currently taking.

Please bring a calendar with you to assist us in making appointments for tests or for scheduling another appointment with our office that will be convenient for you.

If you are Diabetic and covered under Medicare, your insurance requires us to have the date last seen by your primary care physician in order for the visit to be paid. Please bring this information with you.

You may bring this information packet at the time of your visit or mail it to the appropriate address above. If you have any questions, please feel free to contact us.



OFFICE POLICY

As of March 1, 2019, please note the following updates to our policy:

- **You must provide your Photo ID and Insurance Cards with EACH visit. No exceptions. If you do not have these items, you will be asked to reschedule your appointment.**
- **Co-Pays will be collected BEFORE being seen by your Physician. If you do not have your copay, you will be asked to reschedule your appointment and may be charged a \$10.00 reschedule fee.**
- **If your insurance company requires a referral and you do not have that with you, you will be asked to reschedule your appointment.**
- **If you are 15 minutes late for your appointment, you will be asked to re-schedule your appointment.**

We strive to give our patients the best care that we can. We know that your time is valuable, as is the doctors'; therefore: we ask that you arrive on time for your appointment.

- **If you are unable to keep your scheduled appointment, please contact us within 24 hours.**
- **If you fail to call to cancel your appointment or "NO SHOW" to your appointment, there will be a charge of \$40.00. A new appointment will not be made until this is paid. (Price is subject to change without notification).**
- **All Documents requiring Physician completion and a signature, (ex. FMLA, Short Term Disability, Workman's Comp, etc.) will be a \$25.00 fee. Completion of these documents will have a ten (10) business day turn-around time, not to include weekends or holidays. The Office will notify you when the documents can be picked up.**

- There will be a \$35.00 charge for any returned check. This fee, and the amount of the original check used, will need to be paid in cash or with a money order before another new appointment is made.

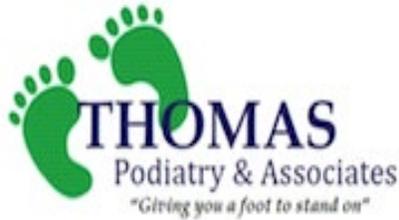
Our office accepts CASH, CHECKS and CREDIT CARDS as form of payments.

Thank You for your cooperation, Thomas Podiatry & Associates

Patient Signature: _____

Patient Name (Please Print): _____

Date: _____



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple providers who may be involved in that treatment directly or indirectly.**
- Obtain payment from third-party payers.**
- Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have been given a copy (if requested) and the opportunity to read it and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

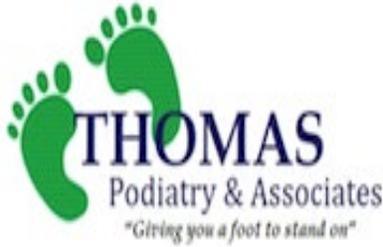
I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____



Kevin Thomas, D.P.M. ~ Trina P. Monis, D.P.M. ~ John Thomas, D.P.M ~ John P. Lydon, D.P.M. ~ John Shapiro, D.P.M

PHARMACY MEDICATION REQUEST

Patient Name: _____ Date of Birth: _____

Address: _____

Name of Pharmacy: _____

Please fax the most current list of medications on file for the above-named patient:

- 1) Name of medication
- 2) Dosage
- 3) Signature

Please fax to: Thomas Podiatry

Fax: 410-749-6807

Patient Signature: _____

Date: _____

A. Notifier: Kevin Thomas DPM PC C. Identification Number: _____

B. Patient Name: _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Custom Made Orthotics (Prescription)	Medicare does not cover the routine trimming of toenails, calluses or orthotics unless you have a systemic condition with severe enough completions to warrant medical necessity.	Custom Made Orthotics- \$400.00
Prefabricated Orthotic ("Off the shelf")		Prefab Orth \$45.00
Routine Foot Care (Trimming nails, shaving calluses etc.)		Routine Foot Care \$65.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. Options: Check only one box. We cannot choose a box for you.
<input type="checkbox"/> OPTION 1. I want the D. listed above. <u>You may be asked to paid now</u> , but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. <u>If Medicare does pay, you will refund any payments</u> I made to you, less co-pays or deductibles.
<input type="checkbox"/> OPTION 2. I want the D. listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
<input type="checkbox"/> OPTION 3. I don't want the D. listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11)

Approved OMB No. 0938-056

YOU ONLY NEED TO FILL OUT THIS FORM IF YOU HAVE MEDICARE