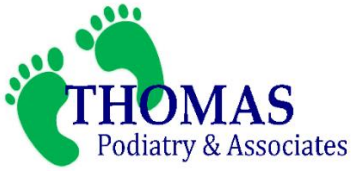


560 Riverside Drive, A-101
Salisbury, MD 21801
Phone: 410-749-0121
Fax: 410-749-6807

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 ☐
Dizziness YES ☐ NO ☐
Nausea YES ☐ NO ☐
Back Pain YES ☐ NO ☐
Prolonged Bleeding YES ☐ NO ☐
Pregnant YES ☐ NO ☐
Wheezing YES ☐ NO ☐
Fainting YES ☐ NO ☐
Vomiting YES ☐ NO ☐
Joint Pain YES ☐ NO ☐
Immune or Healing Disorders YES ☐ NO ☐
Nursing YES ☐ NO ☐

HAVE YOU EVER BEEN TREATED FOR?

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

OTHER MEDICAL PROBLEMS LISTED: _____

SIGNATURE_____**DATE**_____

THOMAS
Podiatry & Associates

PATIENT_____ DOB_____

MEDICATIONS – INCLUDE DOSAGE (PILL, LIQUID, INJECTION)

_____
_____
_____
_____
_____
_____

MEDICATIONS YOU ARE ALLERGIC TO

MEDICATION	REACTION	MILD, MODERATE, SEVERE

SURGERY HISTORY

Procedure_____ Date_____
Procedure_____ Date_____
Procedure_____ Date_____
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_____

THOMAS
Podiatry & Associates

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.
_____ **Initials**

I hereby give consent to Kevin Thomas, DPM, Trina P. Monis, DPM, John Thomas, DPM and or John P. Lydon, DPM, John Shapiro 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.

Authorization to Share Medical Information:

- Can we leave a voicemail on your answering machine? ☐ Yes ☐ No
- Discuss Medical Condition/Treatment/Billing/Collections on my behalf.
- 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.

Please complete the next 6 pages

THOMAS
Podiatry & Associates

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-a-round 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.

AUTHORIZATION AND CONSENT TO TRANSMIT APPOINTMENT REMINDERS VIA UNSECURED INTERNET AND TEXT MESSAGING:

I expressly request, authorize, direct, permit and unequivocally consent to Thomas Podiatry transmitting my APPPOINTMENT REMINDER TO INCLUDE THE DATE, TIME, AND LOCATION to me. I expressly and unequivocally acknowledge that Thomas Podiatry does not have the capability to respond to my electronic mail transmissions through encrypted or otherwise secured Internet connections OR TEXT MESSAGING. I expressly and unequivocally waive any claims or rights with respect to transmission of ePHI or PHI via the unsecured Internet. I knowingly, intentionally and voluntarily waive all rights, claims and damages to the negligence, breach of confidentiality, or other tort and all legal claims that could be asserted against Thomas Podiatry or any of its employees, agents, members or otherwise, as a result of any third person improperly accusing, using, or disclosing my APPOINTMENT INFORMATION as a result of transmission via the unsecured internet OR TEXT MESSAGING. I intend to be legally bound hereby.

e-Mail Address: _____ **Cell Phone #:** _____

Carrier: _____

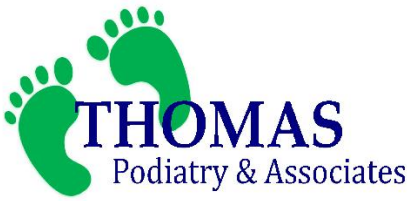
Signature of Patient or Personal Representative: **Date:**

_____

Print Name of Personal Representative: **Relationship to patient (not self)**

_____

☐ **– I wish to "Opt Out" of having any appointment reminders** **Initials:** ____ **Date:** _____



Kevin Thomas DPM / Trina P. Monis DPM / John M. Thomas DPM / John Lydon DPM / John Shapiro DPM

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 & Associates

- ☐ **Salisbury Office Fax: 410-749-6807**
- ☐ **Cambridge Office Fax: 410-228-8521**
- ☐ **Ocean City Office Fax: 443-664-7518**

Patient Signature: _____

Date: _____

A. Notifier: Kevin Thomas DPM PC

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **what is in box 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) **Prefabricated Orthic ("Off the shelf")** **Routine Foot Care (trimming nails, shaving calluses and corns, etc.)**	**Medicare does not cover the routine trimming of nails, corns or calluses or orthotics unless you have a systemic condition with severe enough completions to warrant medical necessity.**	**Custome Made Orthotics- $400.00** **Prefab Orthotics- $45.00** **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.

☐ **OPTION 1.** I want the **D. above** listed above. You may ask to be paid now, 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**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. above** 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.

☐ **OPTION 3.** I don't want the **D. above** 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:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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