T.M. POKABLA DPM LLC
DR. SCOTT BILLY, DPM
248 NILES-CORTLAND RD NE
WARREN, OHIO 44484

PODIATRY

330-856-1700

NEW PATIENTS ONLY

Please be aware this practice will only allow 2 missed initial new patient consult appointments in one year. If you miss the second scheduled appointment, you will not be rescheduled.
****New patient appointments with a 24 hour notice given, when rescheduling or cancelling, DO NOT fall underneath the policy outlined above. *****

Make sure to bring these items with you to your appointment and have them ready:

1. **Your current government issued ID- Must be valid/current and is required for appointment.**
2. **Your current primary and secondary (if applicable) insurance card(s) are required for your appointment for billing purposes. If insurance cards are not present at the time of appointment, the appointment will be rescheduled.**
3. **Specialist co-pays (ready and with you) are due at the time of visit.**
4. **Please make sure that paperwork is filled out thoroughly and brought with you to the appointment.**

****Please keep all paperwork with you and bring it with you on the day of your scheduled appointment. We will not hold on to or store these papers until your appointment. ****

Thank you for choosing us for your podiatry needs and we look forward to treating you in the future.

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

Patient Legal Name:_____ Preferred Name/Nickname:_____

Street Address:_____ City/State:_____

Zip Code: _____ Date of Birth: _____ Social Security #_____

Marital Status: _____ Race: _____ Birth Sex: _____

Family Doctor/PCP:_____ Phone Number:_____

Preferred Pharmacy:_____ Phone Number:_____ Zip:_____

Emergency Contact:_____ Emergency Contact Phone:_____

Occupation and Workplace:_____ How did you hear about us?_____

*APPOINTMENT CONFIRMATION PHONE NUMBER:_____

Primary Phone Number:_____ Secondary Phone Number:_____

INSURURANCE SECTION:

1. PRIMARY INSURANCE:_____
   Policy Holder's Name:_____
   Policy Holder's DOB:_____

2. SECONDARY INSURANCE:_____
   Policy Holder's Name:_____
   Policy Holder's DOB:_____

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 I am responsible for co-pays, deductibles, keeping insurance information up to date with T.M. Pokabla DPM LLC and requesting referrals (if required by insurance). If my insurance does not cover the costs of any services rendered, I agree to be fully responsible for them financially. If I default on any payment, I will be sent to collections and collections protocol will be followed for follow-up appointments. I hereby authorize T.M. Pokabla DPM LLC to release any medical or incidental information that may be necessary for either medical care or processing insurance claims. I understand that a copy of the Notice of Privacy Practices is readily available to me, and I have read and understand the notice that my PHI may be used by the Practice as described in the notice.

-I have read and FULLY understand and agree with the above.

Signature X_____ Date_____
(Patient, Parent, Legal Guardian)

REASON FOR VISIT:_____

Onset of problem:_____
Did the pain or problem begin suddenly or gradually develop over time?_____

If there was an INJURY, fill out below, if not, skip:

Date of Injury:_____ Was this injury work related? YES or NO

Describe injury briefly:_____

Rate pain scale 1-10 (0 no pain and 10 worst possible pain):_____

Describe the pain (ex: sharp, dull, radiating, burning etc.):_____

What makes it better or worse?_____

Athletic Activities:_____How much time each day spent on feet_____hrs

Height:____ft____in Weight_____lbs Shoe Size:_____

SOCIAL HISTORY:

Tobacco use: YES or NO Packs/Day:_____ # of Years:_____ Year Quit:_____

Alcohol use: YES or NO Drinks Per Week_____ Recreational Drug Use YES or NO- In Recovery

MEDICATIONS: Include all prescriptions, over-the-counter, and vitamins.

	Medication Name	Dosage	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			

ALLERGIES: PLEASE LIST REACTION NEXT TO ALLERGIES CHECKED

☐ **No Known ALLERGIES**
☐ Anesthetics- List Reaction-
☐ Codeine- List Reaction-
☐ Iodine- List Reaction-
☐ Nickel- List Reaction-
☐ Sulfa- List Reaction-
☐ Tetracycline- List Reaction-
☐ Adhesives- List Reaction-
☐ Aspirin- List Reaction-
☐ Eggs- List Reaction-
☐ Latex- List Reaction-
☐ Penicillin- List Reaction-
☐ Seasonal- List Reaction-
☐ Other- Please describe-

SURGICAL HISTORY:

☐ Appendix
☐ Cancer- **Please Specify Type** -
☐ Carpal Tunnel
☐ Elbow- Left or Right
☐ Foot -Left or Right- **Please Specify Type**-
☐ Gallbladder
☐ Hip- Left or Right
☐ Knee- Left or Right
☐ Shoulder- Left or Right
☐ Vascular Surgery- **Please Specify Type**
☐ Arthroscopy
☐ Cesarean Section
☐ Heart- **Please Specify Type**-
☐ Hysterectomy
☐ Ovary
☐ Tonsils

FAMILY HISTORY:

☐ Rheumatoid Arthritis
☐ Blood Clots/ Bleeding Disorders
☐ Heart Disease
☐ Cancer- Please Specify Type
☐ Diabetes
☐ Stroke

PAST MEDICAL HISTORY:

☐ 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 NOT LISTED ABOVE: _____

Patients Signature X_____ Date _____

I Have Reviewed this Medical History Doctor's Signature (Dr. Scott M. Billy, D.P.M.) _____

T.M. POKABLA DPM LLC
DR. SCOTT BILLY, DPM
248 NILES-CORTLAND RD NE
WARREN, OHIO 44484

PODIATRY

330-856-1700

Auto/Accident Insurance and Liability Claims

Please be advised this practice does not accept or manage accident/personal injury claims that would be the financial responsibility of an auto-accident insurance or personal liability insurance, such as Progressive, State Farm, All State etc. We do not manage third-party billing claims with accident or liability carriers. This practice does not wait for a settlement from an insurance company, or a liability claim to be resolved. This practice will not bill a car insurance company or at-fault party for your treatment.

This disclaimer pertains to auto or personal liability accidents in which a third-party payer oversees payment. If you choose to still come to this practice for treatment, the patient is expected to pay upfront for their care. Each visit will be on a self-pay basis and payment is due at the time of service and will not be billed. The patient themselves can then manage submitting any documentation for monetary recoupment to their accident or liability insurance carriers for the claim. Please be aware that the patient is ultimately responsible for the full cost of all services rendered. Timely payment for all services is the patient's responsibility regardless of whether it's paid by insurance or by them individually.

If you have an injury/auto accident that is the financial responsibility of a third-party accident or liability carrier, please inform us and we can help guide you in the right direction. If you have any questions, please don't hesitate to reach out to our office manager, Bliss Billy, BSPH, RT(R)(M)(ARRT), and she will be happy to answer any questions you may have.

Signing below means you understand and acknowledge this disclaimer:

Print Name_____

Patient Signature_____

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 X _____

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

ODIATRIST 330-856-1700

NO-SHOW POSTED POLICY ACKNOWLEDEMENT

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

osted Policy-
ou 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.
5. **NEW PATIENTS THAT ARE BEING SEEN FOR INITIAL VISITS AND ARE 15 MINUTES LATE WILL BE RESHEDULED**

**Any appointment that is scheduled which requires 30 minutes or more 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 second (3) missed appointment will be $50. If you miss the fourth (4) schedule appointment, you will be discharged. Our office staff will always inform you if your scheduled appointment falls into this time category, when scheduling your appointment. **

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_____