

SCOTT M. BILLY, DPM
248 Niles Cortland RD NE
Warren, OH 44484-1938
330-856-1700 phone

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Age: _____
SS# _____ Email: _____
Birth Sex: _____ Gender Identity: _____ Preferred Pronouns (he, she, they, etc.): _____
Address: _____ City: _____ State: _____ Zip: _____
Primary phone: _____ Secondary phone: _____
Marital Status: Single Married Divorced Widowed Separated Spouse's Name: _____
Race: African American American Indian Asian White Hispanic Native Hawaiian Other
Primary Care Provider: _____ Phone: _____
Preferred Pharmacy: _____ Phone: _____ Zip Code: _____
How did you hear about our office?: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Primary Insurance: _____ Subscriber: _____ DOB: _____
Secondary Insurance: _____ Subscriber: _____ DOB: _____
Patient's Employer: _____ Phone: _____
Occupation: _____
Responsible Party's Employer: _____ Phone: _____
Responsible Party's Address: _____

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 that **I AM RESPONSIBLE FOR COPAYS, DEDUCTIBLES AND REQUESTING A REFERRAL (if required by my insurance)** from my primary care provider. If my insurance does not cover cost of any services, I agree to be fully responsible for them. If I default on any payment, I will be responsible for any collection costs including, but not limited to: collection agency fees, court costs and reasonable attorney fees incurred to collect this debt. I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original.

I HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE.

Signature: X _____ Date: _____

(Patient, Parent or Guardian)

Please be aware that if I FAIL to give 24 hours notice when canceling or rescheduling my appointment that my account will be charged \$25.00 without notification (extenuating circumstances do apply).

I acknowledge that a copy of the Notice of Privacy Practices is available to me if I should wish to obtain one. I have read (or had the opportunity to read if I so choose) and understand the Notice.

Signature: X _____ Date: _____

(Patient, Parent or Guardian)

REASON FOR VISIT: _____

How long ago did the problem start?: _____ Days / Weeks / Months / Years **(*If injury please skip and see below)**

Was there an injury?:(Describe) _____

Was the injury work related? Yes No

*Date of injury: _____

Did your pain or problem: Began all of a sudden Gradually develop over time

How would you describe your pain? No pain Sharp Dull Achy Burning Radiating Itching Stabbing

Other: _____

How would you rate your pain on a scale from 0 to 10?: (Please Circle)
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

Since the time your pain/problem began, has it: Stayed the same Become worse Improved

What makes it worse?: _____

What makes it better?: _____

Athletic Activity: _____

How much time each day are you on your feet?: _____ hrs

Height: _____ ft _____ in Weight: _____ lbs Shoe Size: _____

SOCIAL HISTORY:

Tobacco Use: Yes No Packs/Day: _____ # of Years: _____ Year Quit: _____

Alcohol Use: Yes No Drinks/Week: _____

Illicit Drug Use: Yes No Type: _____ # of Years: _____ In Recovery: Yes No

PAST MEDICAL HISTORY: (* Please Describe on line listed below)

IF YOU BROUGHT A LIST, YOU MAY SKIP THIS SECTION.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of legs |
| <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Complications* | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Numbness in Feet | <input type="checkbox"/> Toes Turn Blue In Cold |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Falls | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Blood Clots* | <input type="checkbox"/> Gout | <input type="checkbox"/> Sexually Transmitted Infections | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> GERD/Heartburn | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Weight Loss/Gain* |
| <input type="checkbox"/> Cancer* | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Wound Healing Problems |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Stomach Ulcers | |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> High Blood Pressure | | |
| <input type="checkbox"/> Circulation Problems* | <input type="checkbox"/> High Cholesterol | | |

Other Medical Problems: _____

*Describe: _____

MEDICATIONS: (Please include all prescriptions, over-the-counter, and vitamins with dosage; if possible please provide a detailed list)

IF YOU BROUGHT A LIST, YOU MAY SKIP THIS SECTION.

_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES: (For each allergy please list reaction on lines below)

IF YOU BROUGHT A LIST, YOU MAY SKIP THIS SECTION.

- | | | | |
|---|----------------------------------|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> No Known Allergies | <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Adhesives | <input type="checkbox"/> Eggs | <input type="checkbox"/> Nickel | <input type="checkbox"/> Seasonal |
| <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Iodine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Aspirin | | | |

Other: _____

Reactions: _____

SURGICAL HISTORY: (* Please be specific)

IF YOU BROUGHT A LIST, YOU MAY SKIP THIS SECTION.

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Elbow | <input type="checkbox"/> Knee* |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Ovary |
| <input type="checkbox"/> Cancer* | <input type="checkbox"/> Heart* | <input type="checkbox"/> Shoulder* |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Hip* | <input type="checkbox"/> Tonsils |
| <input type="checkbox"/> Cesarean Section | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Vascular Surgery* |

Other: _____

Previous Foot Surgery: _____

HOSPITALIZATIONS: (Please state when you were admitted to the hospital overnight and the reason for the hospitalization)

IF YOU BROUGHT A LIST, YOU MAY SKIP THIS SECTION.

FAMILY HISTORY:

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |

Patient's Signature: _____
(Or Responsible Party)

Date: ____ / ____ / ____

I Have Reviewed this Medical History
Doctor's Signature (Scott Billy, DPM): _____

Date: ____ / ____ / ____

NO-SHOW POSTED POLICY ACKNOWLEDEMENT

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

Posted Policy-

You 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.

****Please be informed that if the doctor is running behind it is because he is treating other patients, and some may require more time than anticipated. Although this does not happen often, it does happen, as he is treating multiple patients for different medical issues and concerns. Thank you****

NEW PATIENTS THAT ARE BEING SEEN FOR INITIAL VISITS AND ARE 15 MINUTES LATE WILL BE RESHEDULED

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 _____

