CNY Foot Surgery &
Podiatry Care P.C.

William M. Dutch, DPM
Douglas Dickson DPM
Nathan Ashby, DPM
Kevin Crable, DPM

6700 Kirkville Rd
Suite 202
East Syracuse, NY 13057
Phone: (315) 701-2929
Fax: (315) 701- 1473
Website:
www.cnyfootsurgery.com

WELCOME TO OUR OFFICE!
Thank you for choosing CNY Foot Surgery and Podiatry Care for your Podiatry needs.

Your appointment is with:

____ Dr. William Dutch
____ Dr. Nathan Ashby
____ Dr. Kevin Crable
_____Dr.Douglas Dickson

On _____ at _____ am/pm

A charge of $25.00 will be assessed for each no show or later cancellation appointment if less than 24 hours' is given.

Please arrive 15 minutes before your scheduled appointment time.

COMPLETE the patient registration in its entirety and bring to the appointment. **DO NOT MAIL OR FAX TO THE OFFICE.**

Please bring the following to our appointment:

Your COMPLETED paperwork. IF PAPERWORK IS NOT COMPLETED OR YOU FORGOT TO BRING IT, WE MAY HAVE TO RESCHEDULE THE APPOINTMENT.
Insurance Card(s)
Any X-rays, CT scan, MRI's with report pertaining only to your feet
Medical records from other podiatrists, and/or orthopedists

Directions to our office
Our office is located on the corner of Kirkville Road and Fly Road in East Syracuse across from the KwikFill Gas Station. Take 481 and get off at the 5W exit. Turn left at the tight and a quick left into our parking lot. We are building C and Suite 202.

We look forward to seeing you.
Sincerely,
The Staff of CNY Foot Surgery

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CNY Foot Surgery and Podiatry Care Office and Financial Policies

Cancellation Policy: If you need to cancel or reschedule an appointment, please call our office within 24 hours of your appointment. Three consecutive cancellations or no shows are ground for discharge.

No Show Policy: If you fail to make your schedule appointments and do not contact our office, you will be charged a **$25 fee.**

FINANCIAL POLICY

- Insurance card(s) are required upon visit
- Copays are due at the time of service
- We will bill secondary insurance if needed
- If you do not have insurance, payment is due at time of service of **$150.00**
- **High Deductible plans:** If you are here for a new patient visit, a payment of **$100.00** will be required of your high deductible plan. If you are an established patient, you will be asked to pay **$50.00** until your deductible is met.
- We accept checks, cash, and credit cards
- Account balances are due within thirty (30) days
- The telephone number to call with account questions is 315-209-9412

Balances: You will receive a billing statement for any unpaid balances, co- insurance, charges determined not covered under your policy.

Copays are due at time of service, Our relationship is with you, not your insurance company. It is your responsibility to contact your insurance company to determine if you have a copay. We will be happy to submit claims on your behalf to your insurance company; however, it is your responsibility on your first visit to provide us with accurate insurance information. If you realize during your course of treatment that you provided us with the wrong insurance information, it is your financial responsibility to pay for treatments rendered.

We understand that temporary financial problems do arise and we encourage you to contact our billing office promptly for assistance in the management of your accounts. Special payment consideration may be extended in the event of unusual circumstances. However, in the that event that it becomes necessary to pursue collection, it will be your responsibility to pay the past due balance as well as any collection fees incurred in the collection process.

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Patient Information:
Name:_____
Address: _____
City: _____ State: _____ Zip:_____
Home Phone: _____ Cell: _____
Work Phone: _____
Date of Birth: ___/___/_____
Social Security #: _____
Birthplace: _____
Email: _____

Emergency Contact Information:
Name: _____
Address: _____
City: _____ State: _____ Zip:_____
Phone: _____
Relationship: _____

Your Regular Physician:
Name: _____
Phone: _____

Your Pharmacy:
Name: _____
Phone: _____

Insurance Information

Name of Primary Insurance	Insurance ID #
Name of Subscriber	
Subscriber DOB	
Name of Secondary Insurance	Insurance ID #
Name of Subscriber	
Subscriber DOB	

Name of Employer: _____ Phone #: _____
Address: _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment.

ASSIGNMENT OF BENEFITS: I, the undersigned, hereby authorize payment of medical and surgical benefits directly to William M. Dutch, DPM of CNY Foot Surgery and Podiatry Care, P.C.

Signed_____ **Date**_____

How did you hear about the practice? (circle one)

Google/Internet Friend/Family Insurance Facebook

Doctor Referral (who?) _____

Other _____

Do you see any other doctors? Who (first and last name of doctor)? And for what reason?

_____

_____

_____

What brings you to our office today?

_____

_____

Have you seen a podiatrist before? _____ Who? _____

Reason you saw him/her?

_____

_____

Past Medical History: PLEASE LIST ANY MEDICAL PROBLEMS YOU HAVE NOW OR HAVE HAD IN THE PAST:

Condition	No	Yes	Date (s)	Describe
Diabetes				
A Wound				
High Blood Pressure				
High Cholesterol				
Reflux Disease (GERD)				
Heart Attack				
Congestive Heart Failure				
Atrial Fibrillation				
Other Heart Disease				
Pacemaker				
Asthma				
COPD (Chronic Obstructive Pulmonary Disease)				
Emphysema				
Sleep Apnea				
Thyroid Disease				
Neuropathy				
Peripheral Arterial Disease (poor circulation)				
Females: Are you pregnant?				
Blood Clots				
Pulmonary Embolus (blood clot to lungs)				
Stroke				
Seizure Disorder				
Renal Failure				
Other Kidney Disease				
Arthritis				
Gout				
Rheumatoid Arthritis				

Auto Immune Disease (Lupus, Inflammatory Bowel Disease, etc.)				
Problems Requiring Treatment with Prednisone or another steroid				
Cancer				
Chemotherapy				
Chronic Sinus Problems				
MRSA				
Anxiety/Depression				
Other				

Diabetic Information:

What was the date you last saw PCP: _____

Do you monitor your glucose regularly? [ ] Yes [ ] No

If No, would you be willing to have the doctor explain the importance: [ ] Yes [ ] No

What was your last A1C and date of test? _____

It usually runs: Morning_____ Noon_____ Dinner_____ Bedtime _____

Test blood _____ times a Day / Week with: _____

Test urine _____ times a Day / Week with: _____

Do you see an Ophthalmologist for yearly eye exams: [ ] Yes [ ] No

Do you follow a routine diet plan: [ ] Yes [ ] No

Do you follow a routine exercise plan: [ ] Yes [ ] No

Would you be interested in learning about your diabetes, treatment options, complication management, and prevention: [ ] Yes [ ] No

Allergies: [ ] No [ ] Yes

Do you have a Latex Allergy? [ ] Yes [ ] No

Medication Allergy	Reactions

Current Medications:

Medication	Dose	Purpose

Surgical History:

Condition	No	Yes	Date (s)	Describe
Kidney Transplant				
Amputation				
Skin Grafts				
Blood Vessel Surgery				
Other Surgeries				

Family Medical History: Do you have a family history of: Diabetes, Heart Disease, Cancer, Bleeding problems, or any other medical disorder? Specify:

_____

SPECIFY THEIR MEDICAL CONDITIONS / DIAGNOSIS DESCRIPTION AND CAUSE OF DEATH

Mother: Alive / Deceased _____
Father: Alive / Deceased _____
Siblings: Alive / Deceased _____
Alive / Deceased _____
Alive / Deceased _____

Personal Habits:

Tobacco Use: **Past:** [ ] Yes [ ] No Amount per day: _____ Date Stopped: _____
Current Use: [ ] Yes [ ] No Amount per day: _____ How many years have you smoked:____
Alcohol Use: [ ] Yes [ ] No Usage per day: _____
Substance Usage: _____

Social History

Marital Status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced

Do you have any children? [ ] No [ ] Yes How many: _____

Who do you live with: _____

Your Occupation: _____ Full Time Part Time Retired Disabled

At work do you: [ ] Sit [ ] Stand [ ] N/A

System Review – ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

Current Head, Eyes, Ears, Nose & Throat

Condition	No	Yes	Description
Frequent Headaches			
Blurred / Double Vision			
Dizziness			
Change in Hearing			
Ringing in Ears			
Sore Throat			
Trouble Swallowing			
Other Current Symptoms			

Current Neurological

Condition	No	Yes	Description
Change in Memory			
Trouble with Balance			
Change in Sensation			
Other Neurological Symptoms			

Current Respiratory

Condition	No	Yes	Description
Colds			
Difficulty Breathing			
Cough / Dark Phlegm			
Other Current Respiratory Symptoms			

Current Cardiovascular

Condition	No	Yes	Description
Chest Pain			
Palpitations/ Irregular Heartbeat			
Swelling in Ankles / Legs			
Other Current Cardiovascular			

Current Digestive

Condition	No	Yes	Description
Heartburn			
Vomiting			
Constipation			
Diarrhea			
Black Stools			
Blood with Stools			
Other Current Digestive			

Current Bladder / Kidney

Condition	No	Yes	Description
Frequent Urination			
Burning Urination			
Blood in Urine			
Difficulty with Urination			
Other Current Bladder/Kidney			

Current Muscles / Bone/ Joints

Condition	No	Yes	Description
Leg Pain – At Rest			
Leg Pain – With Walking			
Back Pain			
Joint Aching Pain			
Swelling of Joints			
Difficult Joint Motion			
Other Current Muscle/Bones/Joints			

Current Skin

Condition	No	Yes	Description
Rash			
New Growths			
Color / Change in Moles			
Other Current Skin			

Other

Condition	No	Yes	Description

Do you have an Advanced Care Directive: [ ] Yes [ ] No If Yes, what type: [ ] HealthCare Proxy [ ] Living Will [ ] DNR

Where is it located: _____

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ___/____/_____