

◆ STAMFORD PODIATRY GROUP, PC ◆ PATIENT BACKGROUND  
(Please Complete All Questions!)

DR: \_\_\_\_\_ DATE \_\_\_\_\_

PATIENTS NAME: (M ) FIRST \_\_\_\_\_ INIT: \_\_\_\_\_ LAST \_\_\_\_\_

ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE (\_\_\_\_) \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SEX \_\_\_\_\_

CELL#: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_ SOC. SECURITY# \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_

IF PATIENT IS A MINOR, WHO IS RESPONSIBLE? NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

RESPONSIBLE PARTY WORK NUMBER: \_\_\_\_\_

WHO MAY WE THANK FOR YOUR REFERRAL? \_\_\_\_\_

**PLEASE ALLOW US TO COPY YOUR INSURANCE CARD(S)** IF YOU DO NOT HAVE YOUR CARD SUPPLY THE INFO BELOW:

PRIMARY INS: \_\_\_\_\_ POLICY# \_\_\_\_\_ GROUP# \_\_\_\_\_ POL OWNER \_\_\_\_\_

SECONARY INS: \_\_\_\_\_ POLICY# \_\_\_\_\_ GROUP# \_\_\_\_\_ POL OWNER \_\_\_\_\_

PROBLEMS THAT HAVE BROUGHT YOU TO OUR OFFICE: \_\_\_\_\_

PHYSICIAN'S NAME & ADDRESS \_\_\_\_\_

ARE YOU UNDER THE CARE OF A DOCTOR? ( ) YES ( ) NO IF YES, PLEASE EXPLAIN \_\_\_\_\_

DO YOU TAKE MEDICATION? ( ) YES ( ) NO IF YES, PLEASE EXPLAIN \_\_\_\_\_

HAVE YOU HAD ANY OPERATIONS? ( ) YES ( ) NO IF YES, PLEASE EXPLAIN \_\_\_\_\_

DO YOU CURRENTLY SERVE IN ANY BRANCH OF THE UNITED STATES ARMED FORCES? YES ( ) NO ( )

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ SHOE SIZE \_\_\_\_\_

I AM ALLERGIC TO - PLEASE CHECK ( ) NOVOCAINE ( ) ASPIRIN ( ) CODEINE ( ) TAPE ( ) PENICILLIN ( ) DEMEROL ( ) IODINE  
( ) SULFA ( ) METHIOLATE ( ) OTHER \_\_\_\_\_

DO YOU HAVE ANY MEDICAL PROBLEMS OR CONDITIONS WE SHOULD KNOW ABOUT?  
( ) HEPATITIS ( ) DIABETES ( ) HIV ( ) ANEMIA ( ) BLEEDING TENDENCIES ( ) CANCER ( ) PHLEBITIS ( ) ARTHRITIS ( ) GOUT  
( ) HIGH BLOOD PRESSURE ( ) EPILEPSY ( ) STROKE ( ) STOMACH ULCERS ( ) ASTHMA ( ) TUBERCULOSIS  
( ) POOR CIRCULATION ( ) OTHERS \_\_\_\_\_

NAME & ADDRESS OF CLOSEST RELATIVE NOT LIVING WITH YOU \_\_\_\_\_

I AUTHORIZE THE USE OF THIS SIGNATURE FOR BILLING. SIGNATURE \_\_\_\_\_  
THERE WILL BE A CHARGE FOR APPOINTMENTS NOT CANCELED 24 HOURS IN ADVANCE

UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE, PAYMENT IS REQUESTED AFTER EACH VISIT.

STAMFORD PODIATRY GROUP, P.C.

24 THIRD STREET STAMFORD, CT 06905-5195  
TELEPHONE: 203 323 1171 FACSIMILE: 203 323 4649  
www.stamfordpodiatry.com

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MARISSA GIROLAMO, D.P.M., FACFAS

FRANCISCO LAGO, D.P.M., FACFAS  
RUI DEMELO, D.P.M., FACFAS

**OUR FINANCIAL POLICY**

**You must notify us of any change in your address, phone number and insurance information.**

**COPAYMENTS** - We are required to collect your copay at the time of service. Please be prepared to pay at each visit.

**ADMINISTRATIVE CHARGE** - Patients will be billed a \$10.00 billing charge if applicable payment (including copay) is not made at the time of service.

★ **MISSED APPOINTMENTS** - If unable to keep an appointment a 24 hr. notice is mandated. Failure do to so will incur a charge (Regular Appt. \$85.00) - (Extended Appt.\$125.00).

**FINANCE CHARGE** - A monthly *finance charge* of 1.25% which is an annual percentage rate of 15% will be added to any unpaid balances after *90 days*.

**REFERRALS** - If your plan requires a referral from your primary care physician it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral you will be required to sign a financial waiver making you responsible for your bill or your appointment will have to be rescheduled.

**SELF PAY AND NON PARTICIPATING PLANS** - Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Your itemized receipt should be attached to your insurance form and sent to your carrier who will reimburse you directly.

**MEDICARE** - We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and the 20% co-insurance provided there is no secondary insurance coverage.

**PRIVACY NOTICE** It is our intent in this office to treat you professionally and provide the best foot care possible. During the course of your treatment it may be necessary for us to share information ( both medical and personal) about you with other professionals within and outside of our office. In some instances information may be sent out of this office for transcription purposes. We will share this data only when necessary and will keep it in strict confidence to protect your identity.

**We accept CASH, CHECK, MASTERCARD, VISA, AMEX AND DISCOVER**  
Thank you for taking time to review our policies. Please feel free to ask any questions or share with us special concerns.

**[ ] PLEASE CHECK: I AUTHORIZE THE OFFICE TO LEAVE PHONE MESSAGES**  
**RELATIVE TO MY CARE**

RESPONSIBLE PARTY

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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**ACKNOWLEDGMENT OF RECEIPT**  
**OF**  
**NOTICE OF PRIVACY PRACTICE**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

\_\_\_\_\_  
Patient Name ( Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Authorized Representative

\_\_\_\_\_  
Signature