AIFC
AFFILIATES IN FOOT CARE

LIEKE T. LEE, D.P.M.
JEFFY ROY, D.P.M.
DAVID DECOSMO, CO

ONE HUNDRED UNICORN PARK DRIVE
SUITE THREE
WOBURN, MA 01801
(781) 979-0919
Fax (781) 979-0334

Welcome to Affiliates in Foot Care, P.C.

Thank you for selecting us to help you with your Podiatric medical needs. We look forward to meeting you. Enclosed you will find an appointment card with your appointment date and time. If you are not certain about our location, please see the enclosed directions sheet.

We would appreciate it if you would **arrive at our office at least 15 minutes before your scheduled appointment** even if you pre-register on your phone or tablet. We will then be able to complete your registration in our system and in turn allow your appointment to begin at your scheduled time.

Your insurance may require that you have an insurance referral from your Primary Care Physician. If you do need one, please call the office of your Primary Care Physician with the name of the physician you are seeing at our office and your appointment date.

Please bring the following information with you for your appointment. This information will help us to evaluate your condition and effectively form a treatment plan.

1. A list of each medication that you take (prescription and non-prescription, including vitamins, supplements and herbal products), the dosage and how often you take each one.

2. The first and last name, address, phone number and specialty of your Primary Care Physician.

3. Your insurance cards. We will need to make copies.

4. X Ray, CT scan or MRI films that you may have had taken that pertain to your present foot problem. Our doctors will need to read the actual films. If your exam was done through Winchester Hospital and Associates, we can access them via the internet.

5. The completed patient information sheet that we have enclosed in this mailing. **Please verify completed information.**

If you have any questions, please feel free to call our office prior to your appointment.

Please be advised that if you do not call to cancel your appointment, there will be a $30 charge for the missed appointment.

Our Mission Statement is to offer quality foot care to our patients in a pleasant and professional environment. Our staff is committed to the needs of our patients working with confident, competent and caring standards of excellence providing understanding and respect of each individual's needs.

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DIRECTIONS TO THE OFFICE

Taking I-93 SOUTH

Going south take exit 36 (Montvale Ave)
Keep left at the ramp
Turn left onto Montvale Ave continue straight
Then turn left onto Unicorn Park Dr. at second set of lights
100 Unicorn Park Dr. is the first building on your left

Taking I-93 NORTH

Going north on I-93 take exit 36 (Montvale Ave)
Turn right onto Montvale Ave
Then turn left onto Unicorn Park Dr.
100 Unicorn Park Dr. is first building on your left

Affiliates in Foot Care, P.C

Please print the following information. Answer all questions completely. **Please sign Page Two of form**.

PATIENT INFORMATION

Last Name: _____ «First Name:_____ DOB:____/____/____

Street Address:_____ City:_____ State____ Zip Code_____

Home Phone:_____ Work Phone_____

Cell Phone:_____ Email Address:_____+_____

Sex:_____ Relationship to Insurance Subscriber: Self_____ Spouse _____Child _____Other_____

SUBSCRIBERS INFORMATION

Last Name: _____First Name: _____

Address: _____ City: _____State: _____ZIP_____

Date of Birth: _____/_____/_____

MEDICAL INSURANCE INFORMATION (Please bring your insurance card. We will need to make a copy.)

MEDICAL INFORMATION

Primary Medical Doctor (PMD):_____

PMD Mailing Address: _____Phone # (___) _____- _____

Pharmacy Used:_____Phone# (___) _____-_____

What foot problem brings you to this office?_____

***Medical Conditions*:** (Check all that apply)
«HomePhone»

__Insulin Dependent Diabetes	__Stroke	__Gout	__Liver Disease
__Non Insulin Dependent Diabetes	__Arthritis	__Lung Disease	__Renal Dialysis
__Poor Circulation	__Heart Disease	__Asthma	__Bleeding Problems
__Rheumatic Fever	__Hypertension	__High Cholesterol	__Neuropathy

__Other (explain) _____

Current Medications: (prescription and non-prescription, attach list if available)

Name	**Dosage**	**Frequency**	**Name**	**Dosage**	**Frequency**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Medications you are allergic to or have had bad effects from:

_____

_____

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Page Two

In case of an emergency please contact: _____
Phone Number: _____ Relationship: _____

Do you have a healthcare proxy: _____ Yes _____ No
If yes, please provide a copy during your visit to scan into your chart.

Thank you.

Patient Authorization

I hereby give my permission to the doctors of Affiliates in Foot care, P.C. to perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in the diagnosis and/or treatment of my feet. I also request that payment of authorized Medicare or other insurance benefits be made directly to Affiliates in Foot Care, P.C. for any services furnished to me. I authorize any medical information about me to be released to the Health Care Financing Administration or other insurance regulators or agents and any information needed to determine those benefits or the benefits payable for related services. I give permission to Affiliates In Foot Care to check my prescription eligibility and prescription history.

Patient Signature: _____Date: ____/____/_____

How did you hear about the practice?

- ☐ Internet/Google _____
- ☐ Friend/Family _____
- ☐ Doctor Referral (Who?) _____
- ☐ Insurance Company _____
- ☐ Facebook
- ☐ Other _____

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WAIVER OF INSURANCE

Date: _____/_____/_____

I, _____ (Patient Name), will reimburse Affiliates in Foot Care, P.C. for any charges that is not covered by my insurance carrier associated with my visits. I am aware that a copy of my Insurance card must be presented at the time of my visit and it is my responsibility to know what my co-pay amount is. I am aware of the additional $15 charge if I choose to have my co-pay billed by AIFC biller.

_____
Patient Name (please print)

_____
Signature

HIPAA

ACKNOWLEDGMENT OF RECEIPT of NOTICE OF PRIVACY PRICTICES

I acknowledge that I had access to 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. (Copy of Notice of Privacy Practices is located on magazine shelf)

_____ _____
Patient Name (please print) Parent or Authorized Representative (if applicable)

_____

Signature

Thank you,

Please be advised that if you choose NOT to or REFUSE to sign the Waiver of Insurance or the Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA), we MUST refuse treatment. Sorry for any inconvenience.

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