Dr. Wendy K. Stinson, DPM

Diplomate, American Board of Foot & Ankle Surgery

3799 Route 46 Ste. #103
Parsippany, NJ 07954
(T) 973-382-6999
(F) 973-381-2355

NJ Lic: 25MD00273900
Tax ID: 01-0862272
NPI: 1053355503
E-MAIL: doctorwendystinson@gmail.com

PERSONAL AND CONFIDENTIAL INFORMATION

FULL NAME: _____

PREFERRED NICKNAME: _____

DATE OF BIRTH: _____Age:_____

BEST PHONE NUMBER: _____

ADDRESS/STREET_____

CITY: _____STATE: _____ ZIP: _____

EMAIL ADDRESS:_____

HOW DID YOU HEAR ABOUT US? (FRIEND? CURRENT PATIENT? WEBSITE? FAMILY?)
_____

OCCUPATION: _____. IF RETIRED, PREVIOUS OCCUPATION: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PHONE NUMBER: _____

PHARMACY: _____

PHARMACY ADDRESS AND PHONE NUMBER: _____

PRIMARY CARE PHYSICIAN: _____ DATE LAST SEEN _____

CARDIOLOGIST: _____ DATE LAST SEEN _____

ENDOCRINOLOGIST: _____ DATE LAST SEEN _____

CHIROPRACTOR: _____ DATE LAST SEEN _____

OTHER:_____ DATE LAST SEEN _____

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Medical History

Check all that apply:

Diabetes		Overactive Thyroid		Dementia	
Congestive Heart Failure		Under Active Thyroid		Neuropathy	
High Cholesterol		Acid Reflux		Peripheral Artery Disease	
High Blood Pressure		Cirrhosis		Stroke	
Low Blood Pressure		Colitis		Transient Ischemic Attack	
Asthma		GERD		Bronchitis	
Arthritis		Hepatitis		Pneumonia	
Gout		Ulcer		Cancer	
Angina/Chest Pain		Kidney Failure		Other: _____	
Coronary Artery Disease		Kidney Stones		Other: _____	

Other Medical Conditions: _____ If Diabetic, recent A1c: _____

Are you currently experiencing any of the following (check all that apply)?

Fever		Loss of Balance		Nausea	
Chills		Pain in Legs when walking		Vomiting	
Fatigue		Cramps		Acid Reflux	
Rashes		Pain in legs at night		Diarrhea	
Itching		Chest Pain		Constipation	
Sores		Kidney Failure		Blurred Vision	
Chronic Cough - productive		Frequent Urination		Blindness	
Shortness of breath		Melanoma		Anxiety	
Easy Bruising		Basal Cell		Depression	
Poor Healing		Squamous Cell		Mood Swings	
Excessive Thirst		Muscle Spasm		Blood Clots	
Numbness		Joint Pain/stiffness		Varicose Veins	
Tingling		Dizziness		Leg Swelling	
Burning		Difficulty Hearing		Wounds/Ulcers	

Do you have any problems with anesthesia? Yes or No If Yes, what _____

Allergies: ___ No Known Allergies: _____

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Medications Taken (include Over the Counter, Vitamins, Supplements, Prescriptions) * If you prefer, a list of your medications can be brought with you to your appointment)**

Name of Medication	Dosage	How often?

Surgeries (include all Major and Minor Procedures

Surgery	Year

Social History

Marital Status: ____ Single ____ Married/Partner ____ Divorced ____ Widowed

Occupation: _____ Exercise: Yes or No; if yes, what _____

Tobacco Use: ____ Never ____Quit (How long ago? ____) Smoke? How many packs a day? _____ Years? ___

Alcohol Use: ___Never ____ Rare ___ Occasional __ Social ___ Moderate ___Daily

Family History

Disease	Who? (parent, grandparent or siblings)
Diabetes	
Poor Circulation	
Amputation	
Cancer	
Heart Disease	
Lung Disease	
Gout	

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Podiatric History

Today's Date: ____/____/_____

First Name: _____ Last Name: _____ DOB : _____

Weight: _____ Shoe Size: _____

What type of problem are you experiencing?

_____

_____

Where is the location of this problem? (Be specific - which foot, location on foot)

_____

_____

How long have you had this problem? _____ Rate your pain on a scale of 0-10 with 10 being severe, _____

How did it occur?

_____ Trauma _____ Injury _____ Gradual Onset ____ Rapid Onset _____ Pain Off/On

What are the characteristics of the pain?

Sharp		**Aching**	
Shooting		**Throbbing**	
Stinging		**Stabbing**	
Burning		**Numbness**	

If needed, provide more information regarding the pain:

_____

Does anything help the pain? _____ Yes _____ No

If so, what_____

Does anything make the pain worse? _____ Yes _____ No

If so, what_____

Have you seen another physician for this problem?_____ Yes _____ No Who? _____

What treatments have you attempted for this problem?

_____

Anything else the doctor should know about the problem? _____

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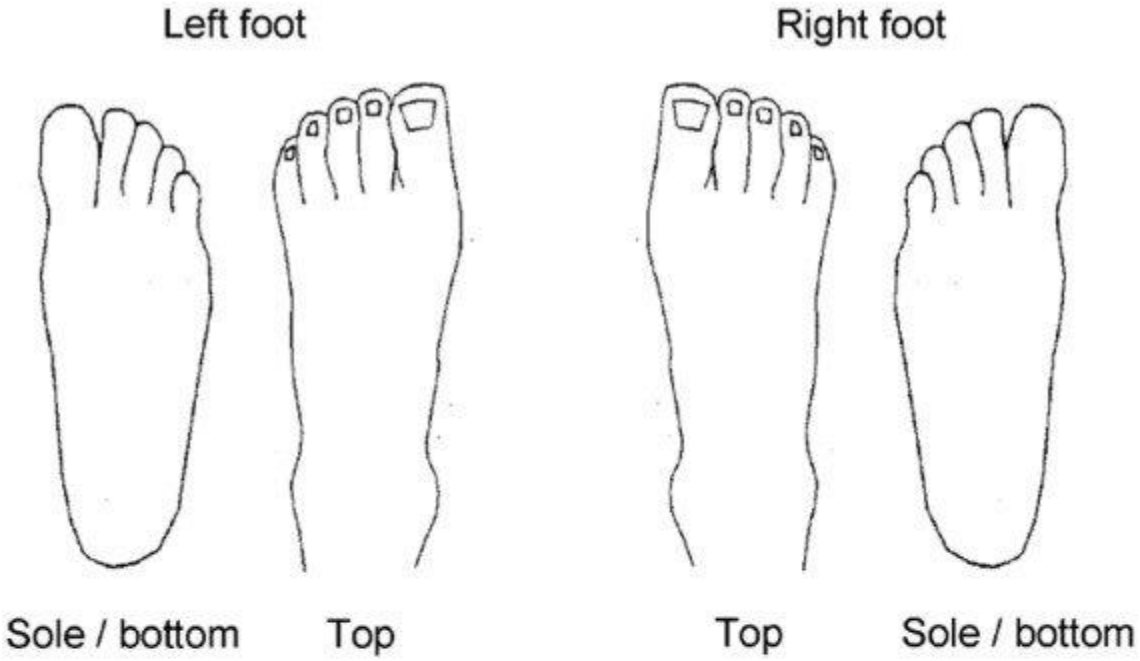
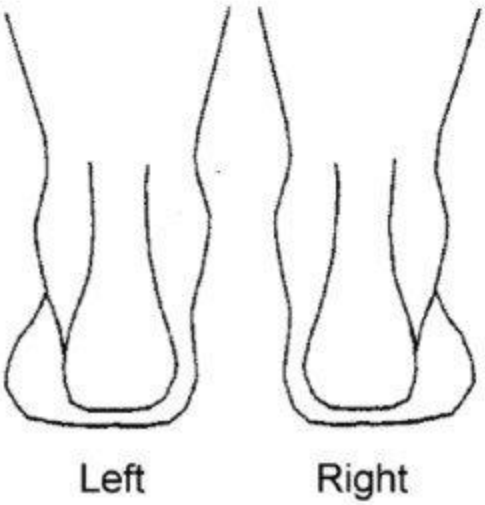
Are there other related problems you would like to discuss? _____

Please indicate on the diagrams below where your pain is (to the best of your ability).





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Office Policies

Dr. Stinson does not guarantee a phone call/text to confirm your appointment. We do our best to notify you the day before, but you are ultimately responsible for knowing when your appointment is scheduled.

Dr. Stinson strives to see all patients at the scheduled appointment time. If you are more than 15 minutes late, Dr. Stinson will try and fit you in that day at some point if possible, however it is not fair to make her other patients wait who were on time. You may also choose to reschedule your appointment.

For your records, Dr. Stinson may take photos of various parts of your treatment both for documentation in your chart, and that may be used on our website. No identifying information (face, name, etc) would be included. If you DO NOT want your photos used in this way, please indicate below.

_____(initial) I DO give permission for any images taken to be used on Dr. Wendy Stinson's website.

_____(initial) I DO NOT give permission for any images taken to be used on Dr. Wendy Stinson's website.

PERMISSION TO TREAT

I grant my permission and consent to be evaluated and receive treatment from Dr. Wendy Stinson with a mutually agreed upon treatment plan for either short term or on-going treatment

CONSENT TO RELEASE INFORMATION TO PERSONAL REPRESENTATIVE

I confirm my permission to share/discuss my medical, billing, and insurance information with the following people.

Name:_____ Relationship: _____ Phone: _____

Name:_____ Relationship: _____ Phone: _____

CONSENT TO RECEIVE MAIL, VOICEMAIL, EMAIL, OR TEXT MEESAGES

I confirm my permission for the following (**Please circle yes or no):**

My preferred method of receiving appointment reminders is: **TEXT** **EMAIL** **VOICEMAIL**

My preferred method of receiving billing information is: **TEXT** **EMAIL** **VOICEMAIL**

My preferred method of receiving medical records/test results is: **TEXT** **EMAIL** **VOICEMAIL**

Signature: _____ Date: _____

Email: _____ Phone: _____

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Financial Agreement

- I authorize the release of information necessary to any entities to secure the payment of benefits submitted for services rendered by Dr. Wendy Stinson, DPM on behalf of myself and/or dependents. I understand information will be provided to a contracted billing service to secure the payment of benefits. I further agree and acknowledge that my signature on this document authorizes claims to be submitted for benefits for any services rendered without obtaining my signature on every claim form. Should the need arise, I also authorize Dr. Wendy Stinson, DPM to file a complaint on my behalf for any dispute or appeal regarding accurate and fair reimbursement for services rendered.
- **I have been advised that Dr. Wendy K. Stinson, DPM is an OUT OF NETWORK Provider**, but does take out-of-network benefits. The office is happy to assist you in finding out your coverage for our office if you email the front and back of your insurance card to stinsoninsuranceandbilling@gmail.com as well as your date of birth. If you don't email us, we assume that you know your benefits – deductible, coinsurance, etc.
- **I understand I am financially responsible for all charges incurred if my insurance carrier denies payment for any reason - deductible, copays, and/or coinsurance.** I understand that a delinquent balance must be paid in full prior to any newly scheduled appointments unless prior arrangements have been made. It is my responsibility to know if my deductible has been met. I will be responsible for all payments in full until the deductible is met.
- In the event my insurance carrier issues a payment directly to me, I agree to reimburse Dr. Stinson for the same amount paid to me, in addition to any co-pays, deductibles, or coinsurances due. I agree to send in a check along with the explanation of benefits upon receipt of payment within 10 business days of receipt of payment. **Failure to send in payment in accordance with this agreement may result in further collection fees incurred and direct billing of the full billable amount to me.**
- I agree to provide Dr. Wendy K. Stinson, DPM with current insurance information **AND** will advise the office of any changes within 30 days from the date of service. I understand that if a claim is not paid because of my failure to provide the correct insurance information, I am fully responsible for the charges.

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a timely manner, any balance of said professional service charges over and above this insurance payment. I also attest that any unpaid balance related to copayment or deductible will only be permitted due to personal financial hardship which will be determined on a case-by-case basis. This “case by case” assessment will use uniform guidelines to determine, in good faith, the ability (or inability) of the patient to pay said balance.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Signature: _____ Date: _____

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Financial Agreement Part II

Dr. Wendy Stinson is a single practice provider. To help keep costs for her patients low, there is not always available staff to collect payment at the time of your visit, and therefore the office manager will call within 2 business days to collect payment, or one of the options below can be utilized for any payments not taken at the visit.

Payment

At the time of service, you will either pay your in-network specialist copay OR if you have a high deductible plan, you will be required to pay $50 towards the deductible. For high deductible plans, after insurance processes the claim, any balance (whether deductible or coinsurance) will be billed to you.

Billing statements will be sent out via email from stinsonbillingandinsurance@gmail.com. Please make sure you have printed your email clearly on Page 1.

Payment is accepted through Zelle or Venmo: @drstinson, www.wendykstinsondpm.com, or in-person.

We impose a surcharge fee of 3% on all Credit Card Transactions. This fee is not greater than our cost of acceptance. Please note that there is no surcharge applied to Debit Cards, Zelle, or Venmo payments. We also accept Cash and Personal Checks. If a personal check is returned, a fee of $35 will be charged and can not be billed to insurance.

Upfront Cost for Certain Services

Cancellation/No Show Fee:
If you are scheduled for a **SATURDAY** visit, and do not cancel by the day before, the charge will be $100. This is not billable to insurance and must be paid by you.

Orthotics: All patients must pay a $125 deposit which is required when the orthotics are cast as they are custom made orthotics and cannot be used for a different patient once ordered.

For patients who use insurance out of network benefits, we will submit the bill to your insurance company, and let you know what your cost is after insurance pays their part. This includes any cost until your deductible is met, and then any co-insurance due after the deductible is met.

For patients who are self-pay, payment is due at the time services are rendered.

Signature: _____ Date: _____