HICKSVILLE PODIATRY
66 W Barclay St
Hicksville, NY, 11801

New Patient Registration Form
(PLEASE PRINT CLEARLY)

Medical Record Number: __________ Today's date ___/___/_____

1. Patient Information				
Last Name:	First Name:	Middle Name:	☐Mr. ☐Mrs. ☐Miss ☐Ms.	
DOB: ___/___/_____ M D Y	Age:	Sex: M: ☐ F: ☐	Martial Status: ☐Single ☐Married ☐Divorced ☐Widowed	Social Security#: _____-_____-_____
Street Address:	City/Town:	State:	Zip Code:	
*Home Phone #:	*Cell Phone #:	Work #:		
Occupation:	Employer Name/Employer Address:	Employer Phone #:		
2. In case of Emergency Contact				
Full Name:	Relationship:	Phone #		
3. Insurance Information	☐ **No Insurance/Self-Pay (Skip to Section 4)**			
Primary Insurance:				
Insured's Name:	Insured's SS #:	DOB:	Group ID #	Policy ID#
Relationship to Insured: ☐Spouse ☐ Parent ☐ Self				
Insured's Employer	Employer's address	Employer's Phone #		
Secondary Insurance:				
Insured's Name:	Insured's SS #:	DOB:	Group ID #	Policy ID#
Relationship to Insured: ☐Spouse ☐ Parent ☐ Self				
Insured's Employer	Employer's address	Employer's Phone #		
4. Additional Information				
How would you like us to give you a reminder in case if you have next appointment with us? ☐Home Phone # ☐ Cell Phone # ☐Email ☐Text Message				
Email Address (if checked above):				
How did u hear or find out about our practice/office? ☐ Doctor _________________ ☐ Friend ☐ Internet/Google ☐ Family Members ☐ Facebook ☐ GOOGLE ADS ☐ BING ☐ OFFICE SIGNS ☐ Other ______________ ☐ Zocdoc ☐ Yelp				
Whom may we thank for referring you?				
Primary Care Doctor: ______________________ Address:________________________________ City: _____________________ Zip code: _______________ PCP Phone #: ___________________				
Shoe Size: ____________________ Height: __________ Weight: _________Pounds				

Medical History, Social and Family History Page

General

What is your weight: _______________

What is your height: ______________

What is your shoe size: ______________

Allergies, Food and Drug intolerance

- ☐ Adhesive/Tape
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Latex
- ☐ Shellfish
- ☐ Seafoods
- ☐ Sulfa
- ☐ Food/Other:______________________
- ☐ No known food and drug allergies

Medications:

List all medications you are taking:

Name	Strength/Dosage

Surgeries, Injuries, and Illnesses:

Type	Date

Medical History

Mark "yes" or "no" to indicate if you or a Family member have any of the following:

Personal		Family
Yes No	Anemia	Yes
Yes No	Arthritis:	Yes
Yes No	Artificial Heart	Yes
Yes No	Acid Refulx	Yes
Yes No	Asthma	Yes
Yes No	Back Problems	Yes
Yes No	Bleed Easily	Yes
Yes No	Cancer	Yes
Yes No	Chest Pain	Yes
Yes No	Poor circulation	Yes
Yes No	Diabetes	Yes
Yes No	Epilepsy/seizure	Yes
Yes No	Fibromyalgia	Yes
Yes No	Gout	Yes
Yes No	Heart Disease	Yes
Yes No	Hemophilia	Yes
Yes No	Hepatitis	Yes
Yes No	High blood pressure	Yes
Yes No	HIV +/ AIDS	Yes
Yes No	Kidney Problems	Yes
Yes No	Leg cramps	Yes
Yes No	Liver disease	Yes
Yes No	Lung/Respiratory	Yes
Yes No	Menopause	Yes
Yes No	Mental Illness	Yes
Yes No	Phlebitis/Clots	Yes
Yes No	Psoriasis	Yes
Yes No	Rheumatic Fever	Yes
Yes No	Sickle Cell Disease	Yes
Yes No	STD	Yes
Yes No	Stroke/CVA	Yes
	Which side? ____________	
Yes No	Thyroid Problems	Yes
Yes No	Tuberculosis	Yes
Yes No	Stomach Ulcers	Yes
Yes No	Recent Weight Change	Yes

Exercise and Orthotics

In what athletic activities do you participate?

____

# of days per week exercising? __________

Do you wear store-bought arch supports? Yes No

Do you wear custom orthotics? Yes No

If yes, who made them: ________________

How old are the orthotics? ______________

Social History

Your Occupation?

____

Do you smoke? Yes No

Are you a past smoker? Yes No

How much? ____ packs/ ________

Years smoked: ________________

Drink Alcohol? Yes No

How much? ___________________

Recreation Drugs? Yes No

What? ___________________________

Are you pregnant? Yes No

If Over age 65 – history of falls within last 12 months: Yes No

If diabetes, history of foot ulcer? Yes No

Diabetic Peripheral Neuropathy? Yes No

Pharmacy Information:

Preferred Pharmacy: ________________________

Town: _________________________________

Zip code: ______________________

Phone #: _________________________________

Current Podiatric Problems

What is the chief complaint(s) that brings you to our office for medical treatment? (Include foot, ankle, leg, knee, hip and back complaints):

____
____
____

Have you ever been under the care of a podiatrist before: Yes No

If yes, Name ______________________________ Last visit: ___________________

Symptoms of Current Problem (circle or fill in your answer)

Which Side: Right Left Both

Type of Pain: Dull Achy Throbbing Burning Sharp Shooting Tingling Stabbing

Area of Pain: Bottom of Heel Back of heel Arch Ball of foot Big toe Top of foot Ankle No Pain Other / Details: ____

Onset: Slow Sudden Traumatic **Has pain gotten**: Better Worse Stayed the Same

How long has this been a problem for you?: ______Days Weeks Months Years

What aggravates condition? Walking Running Standing Shoes Daily Activities First steps after rest Resting Dress shoes High heel Flat shoes Closed shoes Other:________________________________

Severity: Mild Moderate Severe Rate your pain scale of a 0 to 10? _____________

What have you tried to relieve the pain? Changing shoes Anti-inflammatory meds Decreasing activities Heat Prefabricated arch support Custom orthotics Stretching Injections Physical Therapy Surgery Antibiotics Other OTC meds Padding Massage Acupuncture Soaking Other: ______________________________________

After it starts, how long does pain last? ______________________________

Have you ever had a similar pain before? ____

Was this problem caused by an accident or injury? Yes No Work-related injury? Yes No

How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

I certify that all of the information on my registration form is true and correct to the best of my knowledge that I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that throughout my treatment, it is my responsibility to inform the doctor and his office staff of any changes in the information or new update to the information listed above. I give permission to the doctor at Hicksville Podiatry, A division of Happy Feet Podiatry PLLC, to administer and perform any diagnostic, therapeutic and/or operative procedures as may deemed medically necessary in diagnosis and/or treatment of my feet and related conditions. I understand and agree that because of human variance and response, it is not possible to warrant the outcome of any medical care or service. Patient/minors under the age of 18, will not be treated without a parent or legal guardian present. If another family member, caretaker or friend, over the age of 18 will be present; written consent from the parent/legal guardian stating as such must be presented at the time of the appointment.

______________________________ ________________________________
Print Name of Patient Print Parent/Legal Guardian

______________________________ ________________________________
Patient signature Parent/Legal Guardian Signature

Date: _______________________

E-Prescribing Consent

E-prescribing is defined by a physician's ability to electronically send an accurate, error free, and understandable prescription directly to your pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-prescribing greatly reduces medication errors and enhances patient safety. The Medicare modernization act 2003, listed standards that have to be included in an E-prescribing program. These include: Formulary and benefit transactions, which gives the prescriber information about which drugs are covered by a drug benefit plan; medication history transactions, which provides the physician with information about medications the patient is already taking to minimize adverse drug events. I authorize Hicksville Podiatry, Division of Happy Feet Podiatry PLLC, to view my external prescription history via electronic E-prescribing services. I understand that prescription history from multiple, other unaffiliated, providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by the providers and staff of Hicksville Podiatry, Division of Happy Feet Podiatry PLLC, and it may include prescriptions back in time for several years and psychiatric conditions. If applicable, I understand that my prescription history will become part of my record at this practice. Understanding all of the above, I hereby provide informed consent to Hicksville Podiatry, Division of Happy Feet Podiatry PLLC, to enroll me in the E-prescribe program. This consent will remain enforced until revoked or changed.

______________________________	______________________________
Patient signature	Parent/Legal Guardian Signature
______________________________	______________________________
Patient Name (Please Print)	Date Signed

MEDICARE PATIENT SIGNATURE ON FILE AUTHORIZATION :

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Davinder Bhela, DPM for any services furnished to me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Medicare patient signature: ______________________ Date: ________________

Print name of patient: _________________________

Hicksville Podiatry Financial Policy, Payment/Office Policy, and Assignment of Benefits
Effective February 16th, 2021

We realize that there are many choices and thank you for choosing Hicksville Podiatry for your foot and ankle care. At Hicksville Podiatry, we believe that all patients who are given care at this office deserve the best medical care that can be provided. In order for us to continue to provide with the highest quality foot care and latest advanced technology for our patients, we must ensure that we are able to meet the expenses necessary to operate our office. To ensure that these expenses are met, we have implemented the following statement of our financial Policy with the intention of providing your clear understanding of the fees and costs. Please carefully read and initial by each statement and sign below before any service and treatments are rendered.

Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. We will not become involved in disputes between you and your insurance carrier. We do provide your insurance carrier with information regarding your diagnosis and treatment. We do not get involved in such matters as disputes regarding deductibles, copayments, co-insurances, non-covered charges and "usual and customary" charges. If your insurance carrier does not provide payment within 45 days after treatment, you will be responsible for payment. You are responsible for timely payment on your account. Hicksville Podiatry, is required in accordance with its contract with your insurer to collect from you deductibles, coinsurance and copayments at the time of service. We will try to determine your copay and how much of your yearly deductible under your policy has been met for the year. We will require that you pay any amount not covered, such as un-met deductibles and copayments under your policy, on the day of service. Our policy is to collect it prior to seeing the doctor. If your plan requires to pay coinsurance, you will be required to pay that. If you are unable to pay your copayment at check-in, another appointment will be made for you, unless you have a credit card on file with us. Any additional payment owed will be collected in full at the time of service. If needed, we are happy to work with you to arrange a payment plan.

It is your responsibility to provide us with your current insurance card and photo identification at every visit so that we may bill the correct insurance company in a timely fashion. It will be reviewed or copied every time you are here for a visit, no matter how frequently you are seen. If a claim is rejected because your insurance does not cover the type of service rendered, you will be held responsible for the outstanding balance. Please call the telephone number on your insurance card before your appointment and they will assist you in finding out whether the service to be provided at the appointment is covered, what your copay is and what your deductible is. It is your responsibility to understand your insurance coverage. If your insurance does not cover the cost of your visit or procedure, you will be responsible for the charges for all services rendered. Please educate yourself as to your coverage so that office visits, procedures, testing, and specialist referrals may be arranged to best suit your need.

Once we determine your personal financial obligation or after your insurance company reimburses Hicksville Podiatry, for a portion of your care, we may mail you one (1) statement if needed. Payment is expected upon receipt of the statement. Any account past due by 30 days or more may be subject to submission to our collection agency. If your account becomes delinquent and is placed into our collection process, collection fees will be your responsibility and added to your balance. Hicksville Podiatry, reserves the right to discharge any patient at this point. By signing our financial policy, you agree to pay these added fees, along with any and all costs associated with the collection of your account, including interest charges and attorney fees.

INITIAL: _______ CREDIT / DEBIT CARD ON FILE: Due to the Affordable Care Act (Obamacare), as of January 1st, 2014 , we require a credit or debit card on file with our office if we will be billing insurance for you. You will be asked for a credit card at the time you check in and the information will be held securely. When your portion of the bill is determined (following a review of your copay, co-insurance, and deductible) we will charge your card and a copy of the receipt will be emailed to you. You can cancel the contract at any time once your account is in good standing.

____No Show/Missed appointment: We kindly request 24 business hours notice of any changes to your appointment time. Less than 24 business hours notice may result in a $35 cancellation fee. Failure to provider 24 hours notice of a procedural visit will incur a $75

____ CO-PAYS, Deductibles AND UNPAID BALANCES DUE AT TIME OF VISIT: Please be prepared to pay all co-payments, estimated deductibles, estimated coinsurance and unpaid balances at the time of service. We do not send bills out for your responsibility, so your visit will have to be re-scheduled if you are not prepared to pay your responsibility. If we later receive payment from your insurance, we will refund any overpayment. Failure to collect any dues at time of service can be considered as fraud.

____ UNPAID BALANCES AND AUTOMATIC PAYMENTS. Patient balances are due upon final insurance determination of patient balance and will be charged to your credit card on file. You will receive an email notification or phone call that we will be billing your credit card, and then follow-up with an email receipt.

____ NON-CONTRACTED INSURANCE (Out of Network): If you have an insurance plan that we do not participate with, you may have out-of-network benefits. These benefits typically have a higher copay, coinsurance, and/or deductible out of pocket cost. You will be considered a self-pay, uninsured patient if you do NOT have out of network benefits.

____Written or verbal authorizations from insurance plans are not a guarantee of payment. All claims are reviewed by the insurance carriers after services are rendered and authorization can be denied at the time of review. Denied claims become the patient’s responsibility

____ DEDUCTIBLES: If you have an annual deductible which has not yet been paid in full then any charges incurred up to that amount are due at the time of your visit.

____ **ADMINISTRATIVE SERVICES:** There is a $25.00 charge for each Administrative Service payable prior to service completion. This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability, letters for insurance authorization for brand or non-formulary drugs, and any other administrative item not covered by insurance. (school and work note are excluded)

____ **NON-CUSTOM DURABLE MEDICAL EQUIPMENT RETURNS**: If a patient is unsatisfied with any non-custom Durable Medical Equipment item, it must be returned within 30 days per Medicare guidelines. Returns after 30 days will not be permitted. The item will only be accepted as a return if it is in returnable condition. Any custom durable medical equipment item may not be returned for any reason.

____ MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment.

____ SUPPLIES: For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at time of purchase. We cannot bill for these items. There are no refunds or exchanges on any supplies or products.

____ Respect: We give and expect a respectful and professional environment for all who come to our office. We reserve the right to refuse care in patients who are rude, threatening, or intimidating to any staff member of Hicksville Podiatry.

____There is a charge for requested copies x-rays or medical records. All request must be submitted in writing and please be advised, according to state law, copied records will be processed within 10 business days.

____MEDICARE Only: If you have Medicare, you will be billed only for the unpaid portion of the Medicare allowed services. Your co-insurance will be billed as a courtesy. Hicksville Podiatry

is a participating Medicare provider. Federal law requires all patients be billed for the unpaid 20% of their Medicare-covered services and for their annual deductible.

____All copays, deductibles, co-insurance, and unpaid balance are required before you see the doctor. Most insurance plans allowed providers to collect payment if known estimated patient responsibility amount prior to services being rendered. There is no state or federal laws prohibiting the collection of a deductible at the time of service. However, we require credit card on file if we are not allow to collect deductible for certain insurance plan.

Consent for Assignment of Benefits and Authorization to release Information:

I request and authorize Medicare, Medicaid and commercial health insurance benefits to be paid directly to the provider of Hicksville Podiatry practice under Happy Feet Podiatry PLLC for all services rendered on my behalf. I understand that the doctor's office will bill my insurance as a courtesy and that I am financially responsible for any and all charges, whether or not I am insured at the time of service including all co-pay, any deductibles, co-insurance and other amounts such as non-covered services, benefits services that are out of network, denied and/ or not covered by my health insurance plan that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release any and all medical information necessary to insurance carriers regarding my illness and treatments to process my claim and secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I have read and agree to the terms set forth in the above financial policy. I am financially responsible for any balance due. I agree to make all payments for any copayments, charges due within my current deductible and any unpaid balance from previous visits at the time of my appointment. I agree to the Assignment of Benefits. I understand and agree that the terms of this financial policy may be amended by the practice at any time without prior notification to the guarantor.

I have read Hicksville Podiatry Financial Policy and Office Policy. I understand and agree to this Policy and agree to all initials for each statement.

Patient name: ________________________________

Patient signature: ______________________________

Date: __________________________

PRIVACY PRACTICES (HIPAA) AND CONSENT INFORMATION

This consent form is required by the Health Insurance Portability and Accountability act of 1996 (HIPAA) which requires us by law to inform you of your rights for privacy with respect to the disclosure of your health care information.

We keep a record of the health care services we provide you. You may ask to see and copy that record. If you would like to obtain a copy of your medical records, 0.75 cents each page and $10 per hour for staff time is due upon receipt. Our office has up to 30 days to respond to the request.

I acknowledge that I was provided a copy of the Notice of Privacy Practices as part of this registration process and that I have read (or had the opportunity to read if I so chose) and understood the Notice. **(Please read and sign below)**

I hereby give my consent to Hicksville Podiatry and Dr. Bhela and/or his staff to use and disclose my protected health information for the purpose of treatment, payment and operations of my health care and this practice.

Consent for treatment: I authorize Hicksville Podiatry and any employee working under the direction of Dr. Bhela to provide medical care for me or to the patient, which I am legally responsible for. This medical care may include services and supplies related to my health (or the identified person) and may include (but not be limited to) preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical and mental status/function of the body and the sale or dispensing of drugs, devices, or other items required in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.
Consent for the Release of Information for Payment and Operations: I also authorize Hicksville practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the Privacy Practice Notice.

I understand that as part of my healthcare, Happy Feet Podiatry PLLC may need to reach me by phone.
☐I DO NOT authorize Happy Feet Podiatry PLLC to leave messages on my telephone (home, cell or work) regarding any type of testing result or any relevant medical information
☐I DO Authorize Happy Feet Podiatry PLLC to leave messages on my ___ Cell phone ___ Home phone regarding relevant medical information such as lab/test results and imaging studies

Release of Information:
☐I DO NOT WANT any information discussed with my primary care doctor
☐I hereby give permission to Happy Feet Podiatry PLLC/Hicksville Podiatry to discuss or release my relevant medical information to primary care doctor ______________________

______________________________ ______________________________________
PRINT NAME OF PATIENT PRINT PARENT/LEGAL GUARDIAN

______________________________ ______________________________________
PATIENT SIGNATURE SIGNATURE PARENT/LEGAL GUARDIAN

____
DATE

Credit Card on file or payment in full will be required for all patients

Hicksville Podiatry Discontinues sending Patient Statements

Dear Patients,

As of February 16th, 2021, we have discontinued sending patient statements so you will no longer receive bills from us in the mail. We now require a credit or debit card on file with our office if we will be billing insurance for you. If you do not have insurance, then payment in full is due at the time of service.

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is swiped and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient. Due to 2014 changes in health care (Obamacare), most medical practices will be implementing a similar policy.

We have implemented a similar policy. You will be asked for a credit card at the time you check in and the information will be held securely. When your portion of the bill is determined (following a review of your copay, co-insurance, and deductible) we will charge your card and a copy of the receipt will be emailed to you. You can also request a paper copy from the receptionist at checkout. We only have to swipe your card once per year. On follow-up visits you will be able to pay for co-pays and other charges with the card on file. You can cancel the contract at any time once your account is in good standing. Please note that your card will not be charged unless you have a charge due and no funds are held. This simply allows your card to be charged when a bill is due. This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. If you have any questions about this payment method, do not hesitate to ask.

Frequently Asked Questions:

Why the change?

Many changes are occurring in healthcare as of January 1st, 2014 due to implementation of the Affordable Care Act (Obamacare). In order to continue providing care and to keep medical costs as low as possible we need to ensure that we have a guarantee of payment on file in our office. You will find that over the next year or so most medical practices will require full payment up front or a credit/debit card on file for payment of patient balances.

But I always pay my bills, why me?

We have to be fair and apply the policy to all patients. We have wonderful patients and we know that most of you pay your balances. Unfortunately, this is not the case every time. But with the healthcare changes that are occurring, it is now cost prohibitive to send out bills to collect balances.

How will I know how much you are going to charge me?

You will receive a letter in the mail from your Insurance carrier that explains how much of your office visit they pay and how much you pay. This is called an Explanation of Benefits, or EOB. This letter tells you exactly, according to your health insurance coverage, how much of your health care bill is your responsibility and how much is the responsibility of your insurance to pay.

Then what?

We receive the same letter that you do. It arrives about 10 – 30 days after your appointment. We look at each Explanation of Benefits (EOB) carefully, and determine what your insurance has determined as patient responsibility. This is the same way we normally determine how much to send you a bill for in the mail.

But wait, I'm nervous about leaving you my credit card.

We do not store your sensitive credit card information in our office. We store it in a secure, compliant location in our electronic medical record. We access your information only on this site to process a payment. For security reasons, only the last four digits will be visible to our staff. It is stored on a secure gateway that is completely compliant as required by law – just like at a hotel or rental car agency. We access your information only on this site to process a payment. If you absolutely do not want your credit card on file, then you can choose to pay the entire billed amount at the time of service. If your insurance then pays, we will send you a refund for overpayment.

What if I need to dispute my bill?

We will always work with you to understand if there has been a mistake, and we will refund you if we have made a billing error. We will only charge the amount that we are instructed to by your insurance carrier, in the letter they send to us, in the same way that we normally determine how much to send you a bill for in the mail.

What if I don't have a credit card?

If you do not have a credit card, you can be seen as a self-pay patient and pay 100% for all services in cash at the time of service. We will give you what you need to file a claim with your insurance company.

How can I see my bill? You can either look at the EOB from your insurance company or stop by our office to see your EOB.

What if I don't have insurance?

If you do not have insurance, payment in full is due at the time of service. In this case we do not need to have a credit card on file.

I have read and understand the above information regarding credit card on file:

Signature: ______________________________ Date: ____________________________

No-show and On-time Appointment Policy

We have developed this no-show and on-time appointment policy to best meet the needs of our patients. We welcome your feedback and suggestions and will make updates to this policy as needed.

At the Hicksville Podiatry, we pride ourselves on keeping our appointment schedule on time. One of the ways we do this is by giving each patient enough time to meet with their doctor.

At a busy podiatric practice like the Hicksville Podiatry, it is often impossible to predict what a day will bring. A sudden emergency such as a fracture or an infection throws our well-planned schedule into chaos. On the rare occasion, we have to cancel an appointment, we will call and explain and reschedule as soon as possible.

Unpredictable traffic jams or a toddler who throws a tantrum can cause our patients to be late or miss an appointment altogether. We understand that sometimes being late is unavoidable and usually a quick phone call to the office explaining your tardiness or last-minute cancellation is sufficient.

Late Arrivals

When a patient arrives late for an appointment, if the schedule allows, we will see the patient. There may be a lengthy wait, however, as we will see all on-time patients first. If there isn't any flexibility in that day's schedule, the patient will be asked to wait if it is for urgent care or to reschedule if the problem is not urgent.

No-Shows

If you must miss an appointment please call us as soon as you know you cannot make it. Patients who habitually do not show and do not contact us take time away from other patients and will be asked to find another provider.

Work-ins

If you have an urgent problem, we will likely work you into an already busy schedule. In this situation, be aware that there may be a lengthy wait once you arrive at our office. Usually we will see you within 15 minutes of your scheduled appointment time, but occasionally the wait may be up to 30 minutes