

# THE CENTER FOR FOOT CARE, PC

## WELCOME TO OUR OFFICE

This sheet provides us with information vital to your health and will aid our office in accurately filling your insurance forms. Be assured that this information will remain strictly confidential. Please take a moment to fill out both pages of this form.

### PATIENT INFORMATION

TODAY'S DATE \_\_\_\_\_

Patient's full name \_\_\_\_\_

Marital Status (circle) Single Married Widowed Divorced Sex: (circle) Male Female

Social Security No. \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

Name of Pharmacy & Location \_\_\_\_\_

### RESPONSIBLE PARTY OR NAME INSURANCE UNDER

Name \_\_\_\_\_

Social Security No. \_\_\_\_\_ Birth Date \_\_\_\_\_ Home Phone \_\_\_\_\_

Street Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

### MEDICAL INFORMATION

Family Doctor \_\_\_\_\_ Last visit to Family Doctor \_\_\_\_\_

In case of emergency, please call (Name/Relationship) \_\_\_\_\_ Phone \_\_\_\_\_

### MEDICAL INSURANCE

HMO \_\_\_\_\_ PPO \_\_\_\_\_ Co-Pay \$ \_\_\_\_\_

Primary Company \_\_\_\_\_ Secondary Company \_\_\_\_\_

Subscriber \_\_\_\_\_ Subscriber \_\_\_\_\_

Certificate # \_\_\_\_\_ Certificate # \_\_\_\_\_

Group # \_\_\_\_\_ Group # \_\_\_\_\_

### REFERRAL INFORMATION

Please take a moment to tell us how you found out about our practice. Please check as many as necessary:

- |   |   |
|---|---|
| <input type="checkbox"/> My family doctor, Dr. _____        | <input type="checkbox"/> TV Advertisement                   |
| <input type="checkbox"/> Another doctor, Dr. _____          | <input type="checkbox"/> Web site                           |
| <input type="checkbox"/> Patient from this practice _____   | <input type="checkbox"/> Prologue (4-Doctor)                |
| <input type="checkbox"/> Friend, co-worker _____            | <input type="checkbox"/> Hospital's referral network, _____ |
| <input type="checkbox"/> Yellow page (city/directory) _____ | <input type="checkbox"/> Insurance booklet                  |
| <input type="checkbox"/> Newspaper advertisement            | <input type="checkbox"/> Other _____                        |

The Center for Foot Care, PC

## Medical Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please describe your foot problem: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long has it been bothering you? \_\_\_\_ Days \_\_\_\_ Weeks \_\_\_\_ Months \_\_\_\_ Years

Have you been treated for this problem? ( ) Yes ( ) No

If yes, what has been done? \_\_\_\_\_

\_\_\_\_\_

Have you had any previous foot or ankle surgery? ( ) Yes ( ) No If yes, what was done?

\_\_\_\_\_

\_\_\_\_\_

**Past Medical History:** Current Weight \_\_\_\_\_ Height \_\_\_\_\_

Check any of the following you have or have had problems with in the past:

\_\_\_ Arthritis (type) \_\_\_\_\_

\_\_\_ Asthma

\_\_\_ Anemia

\_\_\_ Bleeding Disorder (type) \_\_\_\_\_

\_\_\_ Breathing Problems

\_\_\_ Cancer (type) \_\_\_\_\_

\_\_\_ Congestive Heart Failure

\_\_\_ Diabetes – Insulin Dependent

\_\_\_ Diabetes – Non Insulin Dependent

\_\_\_ Neuropathy

\_\_\_ Gout

\_\_\_ Joint Replacement \_\_\_ Hip \_\_\_ Knee (L/R)

\_\_\_ Hemophilia (bleeding problems)

\_\_\_ Heart Disease

\_\_\_ High Cholesterol

\_\_\_ Mitral Valve Prolapse

\_\_\_ Hepatitis

\_\_\_ High Blood Pressure

\_\_\_ Kidney Disease

\_\_\_ Liver Disease

\_\_\_ Stomach Problems (ulcers)

\_\_\_ Phlebitis (blood clots)

\_\_\_ Thyroid Disease

Other (Please list) \_\_\_\_\_

\_\_\_\_\_

**Medications:** (please list all prescription medication including dosages, over the counter and Herbal medications, vitamins and diet supplements)

\_\_\_\_\_

\_\_\_\_\_

**The Center for Foot Care, PC  
Medical Information**

**Allergies:** Have you experienced any allergic reactions or adverse effects from the following?

\_\_\_ Penicillin \_\_\_ Aspirin \_\_\_ Cortisone \_\_\_ Novocain or Lidocaine \_\_\_ Tape  
\_\_\_ Codeine \_\_\_ Sulfa Drugs \_\_\_ Iodine/Betadine \_\_\_ Latex

Other: \_\_\_\_\_

Type of reaction: \_\_\_\_\_

Any problems with general anesthetic? \_\_\_ Yes \_\_\_ No

Type of reaction: \_\_\_\_\_

**Surgical History:** Please List any Surgeries and Their Approximate Dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family History:** Please List any Major Medical Conditions in your Immediate Family (Mother, Father, Siblings – list which family member):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Personal Social History:**

Do you smoke? \_\_\_ No \_\_\_ Yes Packs/Day \_\_\_\_\_ # of years \_\_\_\_\_

Do You Drink Alcohol? \_\_\_ No \_\_\_ Yes Amount and frequency \_\_\_\_\_

Thank You!

**The Center for Foot Care, PC**

## Financial Policy

As insurance coverage decreases and the patient's financial responsibility increases, we understand the need for clear communication of our financial policies. To better service the needs of our patients, we have added valuable tools to help you meet your increased medical expenses.

1. We will continue to look to insurance companies for their payment, and assist you in receiving proper reimbursement for our services. Unfortunately, most insurance no longer covers services fully and most current insurance plans chosen by our patients require significant out-of-pocket expenses to be paid by the patient.
2. Our staff has been trained to be able to communicate with you and answer your questions regarding payment and insurance reimbursement.
3. It is your responsibility to verify that all requirements of your insurance plan are met. We will assist you with pre-certification for procedures ordered by our office, but it is ultimately your responsibility to verify whether any care you receive is covered by your insurance plan. This office is not responsible for the expense of treatment, which is not paid by your insurance. With continuous changes in coverage, it is important for you to verify your benefits and be aware of all restrictions and expenses of your plan.
4. In accordance with the requirements of most insurance contracts, we will require payment of office co-payments at the time of service. Any person being seen for treatment or service will be required to pay the necessary co-payment at the time of service. Your insurance company will be notified when this contractual payment is not paid at the time of the appointment.
5. For patients owed balances, we will offer credit card, debit cards, and payment plans to assist you in meeting your financial obligations to our office. You must advise us of any payment you receive from insurance or any third party for our services and forward this amount to our office immediately.
6. If we are a contracted provider on your insurance plan, we will file a claim with your carrier and you will be billed when they have responded to our claim. Upon receipt of their response, payment or denial, you will receive a statement for the amount your insurance company notifies us is your responsibility.
7. If our doctors are not contracted providers for your insurance plan, we will file a claim with the information you provide and you will be billed for the entire amount. You will receive monthly statements and we will look to you for payment. You will be responsible for working with your insurance company to insure prompt payment.
8. If you do not have current insurance card with you, you will be billed for the entire amount and asked for payment at the time of service. It is your responsibility to give us your card at each visit (if requested). We will not be able to file your insurance without a copy of your insurance card.
9. If you have an insurance plan that requires a referral, we will require that the referral be here before we can see you. We will do our best to assist you in obtaining the referral, but to expedite matters it is best for you to contact your primary care physician and have them fax the referral over to us or bring the referral in with you.

I understand these policies and accept responsibility for payment of my account.

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_

**The Center for Foot Care, PC  
Authorization to Release Medical Benefits**

I authorize the release of all medical information necessary to process insurance claim(s) and I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance and other health plans to Center for Foot Care, PC.

Please remember that medical insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and other pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.

**In order to control the cost of billing, we request that the co-pay portion of your office visit be paid at the time of the visit.**

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

To the extent necessary to determine liability of payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

This Assignment will remain in effect until revoked by me in writing. A signed photocopy of this Assignment will be considered as valid as an original.

Signature of responsible party \_\_\_\_\_ Date \_\_\_\_\_

**MEDICARE LIFETIME SIGNATURE ON FILE**

I request that payment of authorized Medicare benefits be made on my behalf to Center for Foot Care, PC for any services furnished me by its physician(s). I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Beneficiary \_\_\_\_\_ Date \_\_\_\_\_

**LIFETIME CONSENT**

I request that payment of authorized Medigap or other Secondary or Tertiary benefits be made on my behalf to Center For Foot Care, PC for any services furnished me by its physician(s). I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services.

Signature of Beneficiary \_\_\_\_\_ Date \_\_\_\_\_

## **The Center for Foot Care, PC**

I hereby give my consent for Drs. Mark Green, John Riley, and Jacob Goldstein dba The Center for Foot Care, PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (The Center for Foot Care, PC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Center for Foot Care, PC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to The Center for Foot Care, PC, Privacy Officer, at 1010 Carondelet Drive #301, Kansas City, MO 64114.

With this consent, The Center for Foot Care, PC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. However, our policy is not to leave detailed messages regarding Protected Health Information or anything related to treatment, payment or healthcare operations.

With this consent, The Center for Foot Care, PC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, The Center for Foot Care, PC may e-mail to my home or other alternative location any items that assist the practice in carrying out TOP, such as appointment reminder cards and patient statements. I have the right to request that The Center for Foot Care, PC restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to The Center for Foot Care, PC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, The Center for Foot Care, PC may decline to provide treatment.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date