COMMERCIAL

Please Do Not Return This Form by Mail, Bring It To Your Appointment

Appointment Date: Time: Location:

PATIENT INFORMATION

Patient Legal Name: ______________________________ Nickname you wish to go by: ______________
Mailing Address: ______________________________ City: ______________State: ____Zip__________
Contact Number (Primary): ______________________EMAIL: ______________________________
How would you like appointment reminder/confirmations (circle one): TEXT EMAIL CALL NONE

Date of Birth: __________Age______ Social Security #: __________________ Birth Gender: _____ Race:______
Marital Status: Minor __ Single __ Married __ Separated __ Divorced __ Widowed ___

Family Physician (First, Last Name) ______________________ YES NO – you can send my PCP Health Information
Other(s) that may request my Health Information: ______________________________
Whom may we thank for referring you? ______________________

Employer: ______________________________Work Phone: ______________________________
Job Title: ____
Retired: _________

Person to Contact in Case of Emergency/To whom we may release Health Information To:
NAME: ____________________________Relationship:______________________________
Address: ____________________________Phone:______________________________

INSURANCE INFORMATION: Name and date of birth of the primary card holder needed.

PRIMARY
Name of Insurance Company______________________________
Name of Insured: ______________________________ Relationship to Insured: ____________________
Insured Birthdate: ______________________________
ID# ______________________________Group # ____________________
Name of Employer: __________________________ Work Phone____________

Do you have any additional insurance? ___ Yes ___No (If yes, Complete the following)

SECONDARY
Name of Insurance Company______________________________
Name of Insured: ______________________________ Relationship to Insured: ____________________
Insured Birthdate: ______________________________
ID# ______________________________Group # ____________________
Name of Employer: __________________________ Work Phone____________

Referrals/Copays: Should your insurance company require a referral from your primary care physician before you can be seen, it is your responsibility to obtain your referral prior to your appointment. If you are seen without a referral, you must be prepared to pay for all services in full at the time they are rendered. All co-payments are due at time of service. You may be BILLED a $25 fee for not paying your co-pay at the time of your visit and for any missed appointments without giving 24 hr. notice. A co-pay is an agreement between you and your insurance and therefore we are allowed to collect it at the time of the appointment

INSURANCE AUTHORIZATION & ASSIGNMENT

Assignment of Benefits- Financial Responsibilities

I authorize my insurance carrier to release information regarding my coverage to Kansas Foot Center, PA..

My right to payment for all procedures, test, supplies and physician services including major medical benefits are hereby assigned to Kansas Foot Center, PA. The assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payment to Kansas Foot Center, PA

I understand that I am responsible for all charges regardless of insurance coverage and acknowledge that, in the event the insurance company does not pay in a timely manner, I will pay in full incurred charges. I also understand that as a courtesy to me, Kansas Foot Center, PA will file my incurred charges with my primary & secondary insurance carriers. I understand that it is my responsibility to ensure that Kansas Foot Center, PA has accurate, up-to-date information on my insurance coverage.

Payment Policy

We are committed to providing you with the best possible care. If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payments for services are due **at the time services are rendered AND ARE ESTIMATES ONLY.** We accept cash, checks, Mastercard, Visa or Discover. We also provide financing; please ask our front desk staff to help you.

Please remember these important factors however:

1. Your insurance is a contract between you, your employer, and insurance company.
2. We file insurance as a courtesy to our patients
3. Not all services are covered benefits in all contracts.
4. If you have questions about your benefits call your insurance company.

We must emphasize that as your podiatric care provider, our relationship is with YOU. While filing the insurance claim is a courtesy that we extend to our patients, all charges are your responsibility whether your insurance company pays or not. If your insurance company has not paid your account in full within 90 days, the balance will be transferred to patient responsibility and we will expect immediate payment arrangements to be made.

There will be a $25.00 fee for all missed or canceled appointments without giving 24 hour notice and will need to be paid prior to being seen.

Returned Checks: There is a $35.00 fee for any check returned for insufficient funds.

If no payments have been made after 90 days from date of service, the Kansas Foot Center PA will send my account to collections unless payment arrangements are made.

I have read and received a copy of the above statement and accept the terms. A duplicate of the statement is considered the same as original

I hereby give my permission for the doctor to render the Podiatric examination and treatment after reading and understanding the patient payment and insurance policy. I understand that I am financially responsible to the Physician for all charges incurred by me or my dependents. I authorize the release of any medical information necessary to process any claim and request payment of insurance benefits due to be paid to the physician. I am financially responsible for any collection and/or attorney fees incurred if my account becomes delinquent. I am financially responsible for any service charges incurred on all returned check.

*__________________________ *__________________________

Patient/Patient Representative Signature Date

I acknowledge that I have read and received a copy of the Kansas Foot Center Notice of Privacy Practices.

*__________________________ *__________________________

Patient/Patient Representative Signature Date

Health Questionnaire-To Better Understand Your Health Status

Patient Name: ___________________________Age: __________Height: __________ Weight: _________ Shoe Size: _______

Describe your current foot problems ____

____

LEFT, RIGHT OR BOTH Feet **Symptom Duration:_________________Rate your pain: 0 1 2 3 4 5 6 7 8 9 10**

Treatment(s)/Methods of Relief have tried ____

Was this an accident of any kind with an open claim? If so, we need the following: Claim #_____________________
Claim managers name and number______________________________ Date of accident_________________________
Place of accident_________________________ Description of what happened___________________________________
____

Allergies if applicable____

Medications (We will take copy of a list)____
____

Medical History-Check if applies to you

General:
____weight gain or loss
Neurological:
____numb feet, burning, tingling
____chronic pain
____epilepsy, seizures
Eyes:
____glasses
____contacts
____glaucoma
Cardiac:
____high blood pressure
____low blood pressure
____heart attack
____stroke
Respiratory:
____asthma
Pregnant: Y or No

Urinary System:
_____kidney disease
Gastrointestinal:
_____liver disease
_____alcoholism
Musculoskeletal:
_____joint pain
_____unequal leg length
_____weak ankles
_____back problems
_____arthritis
_____gout
Endocrine:
_____diabetic
Type I or II
Diabetic doctor________________
Date of last AIC________________

Blood:
_____anemia
_____bleeding problems
_____HIV exposure
Vascular:
_____poor circulation
_____leg cramps
_____varicose veins
_____edema/swelling
_____DVT
Skin/Body:
_____non-healing lesions/sores
_____psoriasis
_____tumor/abnormal growth
_____toenail problems
_____cancer
Autoimmune:
_____Hepatitis A B C

Surgical History:____
____

Social History: Tobacco use: Y or N
Cigarettes, cigars, chewless

Alcohol use: Y or N
Daily or social

Drug use: Y or N

I confirm the above medical history has been completed to the best of my knowledge

*___________________________________
Patient/Patient Representative Signature

*___________________________________
Date