COMMERCIAL

THE KANSAS FOOT CENTER

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
Do we have your permission to leave a detailed voicemail: YES NO
Date of Birth: _____Age_____ Social Security #: _____ Birth Gender: _____ Race: _____
Marital Status: Minor __ Single __ Married __ Separated __ Divorced __ Widowed ___

Pharmacy: _____ Pharmacy Phone #: _____
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: _____ Student: _____

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

Patient Name: _____ DOB: _____

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

Uninsured patients will be billed the same fee schedule unless qualified for financial hardship reduction in fees.

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. If services are paid on after collecting up front, we will refund only when all balances have been paid and no further appointments have been 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

Patient Name: _____ DOB: _____

Health Questionnaire-To Better Understand Your Health Status

Height: _____ **Weight:** _____ **Shoe Size:** _____

Allergies (with Reactions) or NO Known Medical Allergies

_____

Medications (We will take copy of a list) or No Medications (circle one) _____

_____

Taking Daily Anticoagulant or Anti Thrombotic Therapy (blood thinner medication) _____

Medical History: Check if applies to you

General:
_____ Weight Gain or Loss
Amount: _____
_____ On Phentermine

Neurological:
_____ Numb feet, Burning, Tingling
_____ Chronic pain
_____ Epilepsy, Seizures
_____ Dementia, Alzheimer's

Eyes:
_____ Glasses
_____ Contacts
_____ Glaucoma

Cardiac
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Heart Attack
_____ Stroke

Respiratory:

_____ Asthma

Urinary System:
_____ Kidney Disease

Gastrointestinal:
_____ Liver Disease
_____ Alcoholism

Musculoskeletal:
_____ Joint Pain
_____ Unequal Leg Length
_____ Weak Ankles
_____ Back Problems
_____ Arthritis
_____ Gout
_____ Multiple Sclerosis

Endocrine:
_____ Diabetic
Type I or Type II
Diabetic Doctor:
_____
Last A1C: _____
On Hospice:
_____

Blood:
_____ On Blood Thinner
_____ Anemia
_____ Bleeding Problems
_____ HIV Exposure
_____ Vitamin Deficiency B D E

Vascular:
_____ Poor Circulation
_____ Leg Cramps
_____ Varicose Veins
_____ Edema, Swelling
_____ **History of DVT or PE**
_____ Raynaud's
_____ Atherosclerosis

Autoimmune:
_____ Celiac Disease
_____ Hepatitis A B C

Skin/Body:
_____ Non-Healing lesions/Sores
_____ Psoriasis
_____ Cellulitis
____ Tumor, Abnormal Growth
_____ Toenail Problems
_____ Cancer, Type

Surgical History: (Provide dates if possible)

_____ Joint
_____ Stents
_____ CABG
_____ Hysterectomy
_____ No Surgical History

Others: _____
_____

Social History:

Tobacco Use:
_____ Cigarettes
_____ Cigars
_____ Chew less
_____ E-Cigarettes
_____ Former
Date Quit:
_____

Alcohol Use:
_____ Daily
_____ Social
_____ Rarely
_____ Never
_____ Former
Date Quit:
_____

Drug Use:
_____ Yes
_____ No
_____ Former
Date Quit:
_____

Exercise:
Light
Moderate
Daily

I confirm the information provided for my medical history has been completed to the best of my knowledge.

* _____ * _____

Patient/Patient Représentative Signature Date

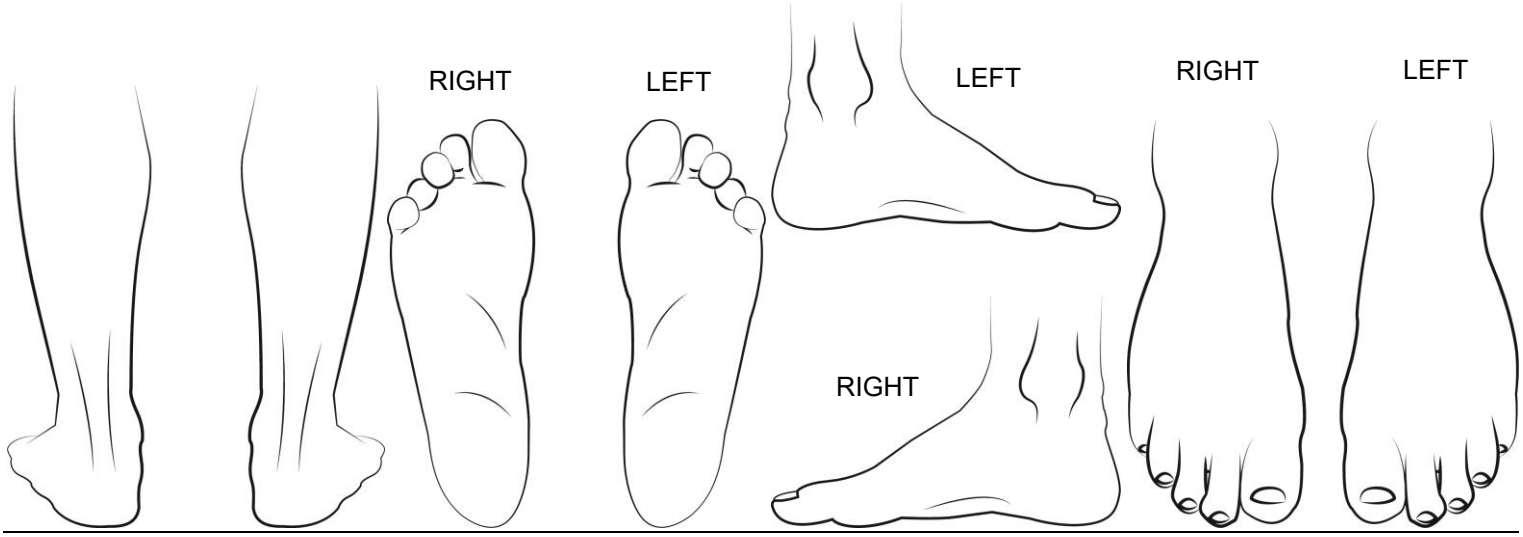
Updated: 06.08.2022

Patient Name: _____ DOB: _____

Your Current Condition/Concern Questionnaire

What are you seeking today: **Consult Only** **Treatment Plan** **Treatment/procedure** **Second Opinion**

Reason for visit (main concern first): _____
Please note that due to other patient appointments, we may only be able to address one concern at a time.



Location of Complaint: Left Right Both Feet **Which is Worse:** Left Right Both Same

Description of Symptoms: _____

Was the condition a result of an: INJURY **Auto Accident/Claim** **Home Accident/Claim** **Work Comp Claim N/A**
If so what is the date, time and location of the condition/injury: _____

Type of Pain (sharp, shooting, dull ache, etc) Describe: _____

Rate the Pain, Scale 1-10 with 10 being Worst Pain: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

Duration/Onset of Symptoms (how long present): _____

Condition related to or begin after a specific event (marathon, sports game etc) _____

What makes the condition worse: _____

What makes the condition better: _____

Treatments for condition (anything you have tried for relief) _____

_____

Has previous treatment made the condition: Improved Worse Stayed The Same

Do you consent for us to take Xrays or Ultrasound if it is recommended for your visit today: Yes No I brought my own images