Buckeye Foot Care

Name **Social Security Number** **Date of Birth**

Address **City** **State** **Zip Code**

Email Address

Cell Phone **Home Phone** **Work Phone** **Ext.**

Primary Care Physician **Date Last Seen**

Emergency Contact **Relationship** **Phone**

Are you the primary carrier of your insurance?_______Yes_________No

If not, who is the primary carrier of your insurance?

Name **Date of Birth** **Relationship**

Preferred Pharmacy and Location

How Did You Hear About the Office or Who Referred You to the Office?

I, with my signature below, authorize Buckeye Foot Care to furnish information to the identified insurance carriers for prior authorization, pre-certification or payment of healthcare services. This information may include claims, copies of records, fax and telephone calls concerning care provided or proposed, and I assign all payments for these services to Buckeye Foot Care. I understand that I am responsible for co-payments, deductibles, all non-covered services, proper referrals and use of participating lab and radiology services. I further understand that my contract with my insurance carrier may or may not cover some services and that it is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I am responsible for all charges that are incurred and I am responsible for all charges whether covered or not by insurance.

Printed Name - Patient/Guardian **Date**

Buckeye Foot Care

Height______________________________ Weight ____________ Shoe size ____________

Reason for today's visit ____

____

Duration of problem: ____________________ Is this injury related? ____________________________

Have you had previous treatment?____

If so what was done? ____

MEDICAL HISTORY

DO YOU HAVE OR EVER HAVE BEEN TREATED FOR THE FOLLOWING (check all that apply):

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Problems
- ☐ Bronchitis
- ☐ Cancer __________
- ☐ Circulatory Problems
- ☐ Diabetes ________
- ☐ Depression
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Fainting Spells
- ☐ Frequent Infections
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Pace Maker
- ☐ Parkinson's Disease
- ☐ Phlebitis
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Hypertension
- ☐ Spinal/Disc Problems
- ☐ Tuberculosis
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Vascular Disease
- ☐ Other __________
- ☐ None of these

Do you smoke?______ If so, how many packs per day?_____ Do you drink alcohol?_____ How much?________

ALLERGIES (check all that apply) :

- ☐ Aspirin
- ☐ Codeine
- ☐ Novocain
- ☐ Penicillin
- ☐ Tapes/Adhesives
- ☐ Sulfa
- ☐ Food ______________________________
- ☐ Other ______________________________
- ☐ Other ______________________________

FAMILY MEDICAL HISTORY

____

____

____

PRIOR SURGERIES

____

____

____

MEDICATIONS (Please include dosage and frequency)

____

____

____

Buckeye Foot Care

Financial Policy

1. It is your responsibility to present your insurance ID card and a photo ID at the time of your visit. In accordance with your insurance company's member handbook, it is your responsibility to provide accurate insurance information.

2. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing statement so that you can attempt to obtain reimbursement from your insurance company.

3. It is your responsibility to ensure that our physicians are in your insurance network.

4. If your insurance plan requires a referral, it is your responsibility to obtain this prior to being seen by our physicians. If this referral is not obtained and your claim is denied, the unpaid balance will be your financial responsibility.

5. All co-payments are due at the time of visit. Post-dated checks are not accepted.

6. The fee for a returned check is $25.00.

7. Once benefits are verified and your financial responsibility is calculated, you will be notified of your payment amount and due date. After you have been notified of the said amount, all balances will be due PRIOR to any further office visits, procedures or surgeries.

8. Payment is due for rendered services 10 days from receipt of your billing statement. Unpaid balances must be paid in full prior to any additional visits unless arrangements have been made with our financial counselor.

9. You are ultimately responsible for payment of charges for services you receive from a Podiatry Inc. Physician.

10. Cancellations for any scheduled appointment or procedure must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date.

11. Patients who fail to keep and/or cancel a scheduled appointment may be charged a $50.00 No Show Fee. There is a $100.00 cancellation fee for scheduled surgeries that are cancelled less than 5 business days from the date of the surgery unless cancellation is due to insurance denial or medical necessity.

12. Medical record requests must be received in writing and at least 72 hours prior to the date needed. No fee will be charged to a patient requesting their medical record for the first time. Any additional requests made after the initial one will be subject to a fee according to State of Ohio law. Fees must be received prior to record delivery. Medical records will be mailed to the authorized address.

13. Administrative Services: There is a $25.00 charge for each required Administrative Service payable prior to service completion. This Administrative Service Fee covers specific administrative services including, but not limited to: forms completion for family medical leave and disability, letters for insurance authorizations for brand or non-brand formulary drugs, letters for employers, school, health clubs and any other administrative items not covered by insurance.

14. During the course of your care outside diagnostic services or additional durable medical equipment may be required. The provider of these services will bill your insurance company separately and you will be responsible for all charges as determined by your insurance company policy to these individuals. Podiatry Inc. does not have any responsibility for those services or fees.

Print Name ______________________ Signature ______________________ Date ______________

Buckeye Foot Care
Howard M. Kimmel, D.P.M., F.A.C.F.A.S.

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

______________________________________ ____________________
Patient Name (please print) Date

____
Parent or Authorized Representative (if applicable)

____
Signature

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communications barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other

____