Buckeye Foot Care

Name_____ Date of Birth_____ Age_____

Address_____ City_____ Zip_____

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Emergency contact and phone number_____

Primary Care Physician_____ last seen_____

How did you hear about us_____

Email address_____

Reason for your visit_____

Height_____ Weight_____ Shoe size_____

Duration of the problem_____ Injury related?_____

previous treatments_____

Pharmacy/location_____

Medical History

Have you ever been treated for the following (check all that apply)

□Acid reflux	□Depression/Anxiety	□Asthma	□Circulatory Issues
□Diabetes	□Hypertension	□Cancer	□ Heart attack
□Heart Murmur	□Arthritis	□Polio	□Parkinson's
□Rheaumatic Fever	□Frequent Infections	□Anemia	□Bleeding problems
□Phlebitis	□Stroke	□Gout	□Pace Maker
□Epilepsy	□Vascular Disease	□Kidney Disease	□_____

Do you smoke?_____ If so how much_____ Do you drink_____ How much_____

Allergies

□Novocaine □Aspirin □Codeine □Tapes/Adhesives □Latex □Sulfa □Penicillin

□Food_____ Other_____

Surgeries_____

Medications_____

I, with my signature authorize Buckeye Foot Care to furnish my information to the given insurance carriers for prior authorizations, pre-certification or payment of the health care services. This information may include but is not limited to copies of medical records, fax and phone calls concerning provided care or proposed care. I assign all payments to these services to Buckeye Foot Care. I understand that I am responsible for copayments, deductibles and all non covered services, proper referrals and use of participating labs and radiology services. I further understand that my contract with my insurance carrier may or may not cover all or some of the services and that is my responsibility to obtain information about my health plan and coverage. If I seek care outside of my 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.

Name_____ Signature_____ Date_____

Buckeye Foot Care

- It is your responsibility to present your insurance cared andphot 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.

- If you do not have insurance or do not present a valid insurance card, you will be responsible for your 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.

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

- If your insurance plan requires a referral, it is your responsibility to obtain it prior to being seen in the office, If this referral is not obtained and your claim is denied, the unpaid balance will be youre financial responsibility.

- All copays are due at the time of service. Post dated checks are not accepted.

- The fee for a returned check is $25.00

- Once benefits are verified and your financial responsibilty is calculated, you will be notified of your payment amount and due date. After you have been notified of said amount, all balances will be due prior to any additonal office visits or procedures or surgeries.

- Payment is due for all rendered services 10 days from the receipt of your billing statement.

- You are ultimately responsible for payment of charges for services that you receive from a Podiatry Inc. physician.

- Cancellations for any scheduled appointments or procedures must be received atleast 24 hours prior to the scheduled appointment. Cancellations for scheduled surgeries must be received atleast 5 business days prior to the scheduled surgery date.

- Patients who fail to keep and or cancel their appointments will be subject to a $50.00 no show fee. There is a $100.00 fee for surgeries that are cancelled less than 5 business days before the surgery date, unless cancellation is due to Insurance denial or medical necessity.

- Medical record requests must be received in writing and atleast 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 the State of Ohio Law. Fees must be received prior to the record delivery. Medical records will be mailed to the authorized address.

- 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 disibility, letters for Insurance authorizations for brand or non brand formulary drugs, letters for employers, school, health clubs, and or any other administrative items not covered by Insurance.

- 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

ACKNOWLEDGEMENT 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) 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 the receipt of our Notice of Privacy Practices, But acknowledgement could not be obtained because:

___ Individual refused to sign

___Communication barriers prohibited obtaining the acknowledgement

___An emergency situation prevented us from obtaining acknowledgement

___Other

BUCKEYE FOOT CARE

CLINIC CANCELLATION AND NO-SHOW POLICY

Effective as of 1-1-2025 a 24 hour notice will be required for all canceled appointments. Cancellation of an appointment less than 24 hours prior will be considered a no show and you will be subject to a fee.

Please appreciate that when you forget to cancel your appointment without giving notice, we are usually unable to fill that time slot.

***First no call no show is subject to a $35.00 fee**
***Second no call no show is subject to a $50.00 fee**
***After the third no call no show you will be banned from making future appointments.**

****Surgical visits in the office: if you do not call to cancel you will be subject to a $50.00 fee.**

****Surgical visits out patient : if you do not call to cancel you will be subject to a $100.00 fee**

printed name_____

signature_____

date_____