George Tjamaloukas, D.P.M.
Kathy Tjamaloukas, D.P.M.
Podiatric Foot and Ankle Surgeons

PATIENT LAST NAME: ____

FIRST: ____ **Middle:** _____________________

DATE OF BIRTH: ____________**AGE:** _____**Social Security:** _______________**Marital Status:** ____

Mailing Address: __________________________________**APT #:**_________

City: __________________________**State:** __________ **Zip:** ___________

E-mail Address: ________________________@__________**Home Phone:** _________________

Cell Phone:________________**OK to leave message:** ___**Yes**____**No**

Emergency Contact: ___________________**Phone:** ________________**Relationship**___________

INSURANCE INFORMATION

Primary Insurance: _________________________________ **PLAN TYPE: HMO PPO EPO FEP**

Subscriber/Member ID: _______________________

Subscriber Name: ____________________________

Subscriber Date of Birth: _________________ **Group #:** ______________

Referral Needed: ___**Yes** ___**No** **Referral Obtained:** ___**Yes** ____**No**

Secondary Insurance: _______________________________**PLAN TYPE: HMO PPO EPO FEP**

Subscriber/Member ID: __________________________

Subscriber Name: ______________________________

Subscriber Date of Birth: _______________**Group #:** _____________

AUTHORIZATION FOR RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I request the services of **GEORGE TJAMALOUKAS, D.P.M., F.A.C.F.A.S.** in the State of Florida, and all personnel, the consent to examination, diagnostic procedures and treatment which may need to be performed on my behalf. Also, I authorize the release of any medical information, to any person or corporation, necessary to process my claim.

I hereby authorize direct payment for all valid insurance benefits including all major medical benefits, be made on my behalf to: **COMPREHENSIVE FOOT AND ANKLE CENTER PA** and I will be financially and legally responsible for any charge(s) not covered by assignment. I certify that I have read the above authorizations and understand and agree to same, and also certify no guarantee or assurances have been made as to the results that may be obtained.

____ ___________________

SIGNATURE OF PATIENT OR AUTHORIZED PERSON **DATE**

MEDICAL HISTORY **Date: _______________**

PATIENT FULL NAME: ____

DOB: ________________________

FAMILY PHYSICIAN: _________________________PCP Office Number: _________________

Date Last Seen by Family Physician: ___________________

Height: _____________ Weight: ____________ Shoe Size: _____________

Former Foot Doctor: _________________________ Last Visit:____________________

CHIEF COMPLAINT____

How long has this been a problem? _______________________________

Any Previous Treatment: ____

1. **ARE YOU IN GOOD HEALTH? _____YES _____NO**
2. **ARE YOU NOW/HAVE BEEN UNDER A PHYSICIAN'S CARE DURING THE PAST TWO YEARS? _____YES _____NO**
3. **DO YOU SMOKE: ____ YES _____ NO -*(If YES, how many packs a day?)* ____________**
4. **DO YOU DRINK? ____ YES _____ NO -*(How much and how often?)* _______________**
5. **DO YOU EXERCISE: ____ YES _____ NO -*(How much and how often?)* _______________**

CHECK ANY OF THE FOLLOWING SURGERIES YOU HAVE HAD: *(Please check mark)*

___TONSILS ___FOOT ___APPENDIX ___FEMALE ___GALLBLADDER ___GASTRIC

___HERNIA ___RECTAL ___INJURIES ___FRACTURES ___OTHER: _________________

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? *(Please check mark)*

_____PENICILLIN ____ASPIRIN

_____CODEINE ____IODINE

____TAPE _____LOCAL

___ANESTHETICS ____OTHER: __________________________________

PATIENT FULL NAME:____

Date of Birth: __________________

Date: _________________________

MEDICAL HISTORY

CHECK ANY OF THE FOLLOWING:

___ARTHRITIS ____ASTHMA ____BACK PROBLEMS ____BLEEDING DISORDERS ___BLOOD CLOTS

____CARDIAC ____DIABETES ____EPILESPY ____GOUT ___HEPATITIS ____HIV/AIDS

____KIDNEY ____LIVER ____NERVOUS DISORDER ___PHLEBITIS ____POOR CIRCULATION

____ RHEUMATIC FEVER ____STROKE ____TB ____ULCERS

OTHER: ____

FAMILY HISTORY

(LIST ANY THAT APPLY- Examples: Diabetes/Gout/Heart Problems):

MOTHER: ____

________***DECEASED?*** ***CAUSE OF DEATH:*** __________________________

FATHER: ____

________***DECEASED?*** ***CAUSE OF DEATH:*** __________________________

BROTHER: ____

________***DECEASED?*** ***CAUSE OF DEATH:*** __________________________

SISTER: ____

________***DECEASED?*** ***CAUSE OF DEATH:*** __________________________

OTHER: ____

________***DECEASED?*** ***CAUSE OF DEATH:*** __________________________

PATIENT FULL NAME: ____

DATE OF BIRTH: ____________________

Date: ____________________________

LIST ANY/ALL MEDICATIONS YOU ARE TAKING:

Medication Name: ____________________________DOSE: ____________How Often?____________

Medication Name: ____________________________DOSE: ____________How Often?____________

Medication Name: ____________________________DOSE: ____________How Often?____________

Medication Name: ____________________________DOSE: ____________How Often?____________

Medication Name: ____________________________DOSE: ____________How Often?____________

Medication Name: ____________________________DOSE: ____________How Often?____________

Medication Name: ____________________________DOSE: ____________How Often?____________

Medication Name: ____________________________DOSE: ____________How Often?____________

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Medication Name: ____________________________DOSE: ____________How Often?____________

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Medication Name: ____________________________DOSE: ____________How Often?____________

FINANCIAL POLICY DISCLOSURE AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Comprehensive Foot and Ankle Center is committed to providing you with the best possible medical care. If you have special needs, we will work with you. The following information is provided to help avoid any misunderstandings about billing for professional services rendered.

Our office participated in a variety of Insurance Plans,* ***IT IS YOUR RESPONSIBILITY TO:*

-BRING YOU INSURANCE CARD AT EACH VISIT

-CO-PAYS ARE DUE AT THE TIME SERVICES ARE RENDERED, AS MADATED BY YOUR INSURANCE COMPANY

-BE PREPARED TO PAY YOUR DEDUCTIBLE AND CO-INSURANCE AT THE TIME SERCICES ARE RENDERED

-PAYMENT CAN BE MADE BY CASH, CHECK, VISA, MASTERCARD OR CARE CREDIT (There will be a $45 Check Fee for all returned checks)

-A $45 charge is assessed to patients who do not cancel a scheduled appointment within 24 hours or do not come for their visit. A $250 charge is assessed to patients who do not cancel a scheduled surgery within 3 business days or do not show up on their scheduled surgery day.

If you have with which we are not contracted, we will file the claim if you have out-of-network benefits, any deductible or co-insurance that you are responsible for is due at the time of service. If your insurance does not provide out-of-network benefits, then you are responsible for payment in full. We offer discount prices for self-pay patient (Please see the office staff for information).

REFERRALS: Please provide required referrals ***prior*** to visit. If a referral is not received on the day of service, ***your visit will be rescheduled.***

If the patient is 18 year or younger, the patient's legal guardian **must** signed below. When a minor is seen, all the same rules and regulations apply.

Our practice firmly believes that a good physician/patent relationship is based on understanding and good communication. Questions about financial arrangements should be directed to the front office as payment plans are available. **I HAVE READ, UNDERSTAND, AND AGREE TO THIS FINANCIAL POLICY AND AND 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 if I so chose) AND UNDERSTOOD THE NOTICE OF PRIVACY PRACTICES.**

__________________________ _____________ ____________________ _______

PATIENT NAME *(PLEASE PRINT)* **Date of Birth** **Signature** **Date**

CFAC CODING DISCLOSURE/AGREEMENT FORM

PATIENT FULL NAME: ___________________________________
(Please Print)

PATIENT DOB: ____________________

I agree to pay for the podiatric services that I receive today from the doctor/providers of this practice if my insurance company refuses to pay, for any reason. I understand that it is my responsibility to be informed about my insurance benefits and I agree to pay in advance any amounts that need to be applied of my deductible as well as any percentage that is my responsibility. This office will file a claim on my behalf, however, if my insurance company denies payment for any *reason (e.g. non-covered services, does not pay for orthotics/braces/shoes/inserts, my failure to secure a referral from my primary care physician)*, I will pay for the denied services upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is, for the purpose of this agreement, a refusal to pay.

I further agree and understand that this office can only code and file a claim for my visit (s) with a diagnosis that was encountered and documented in my medical record. Thus to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate, considered to be fraudulent practices and could potentially result in civil and criminal prosecution.

In the event I do not pay for these or any other services provided, I agree to pay all cost fo collection, including reasonable attorney fees, whether or not a law suit is commenced as part of the collection process. This disclosure/agreement form is provided with the understanding that the publisher is not engaged in rendering legal or accounting advice.

___________________________________ __________________

Patient/Parent or Guardian Signature **Date**

1. Please list the family member(s) or other person(s), if any, whom we may inform about your general medical condition and your diagnosis *(including treatment, payment and health care operations):*

PLEASE PRINT

NAME: ____Phone Number: ____________________
NAME: ____Phone Number: ____________________
NAME: ____Phone Number: ____________________
NAME: ____Phone Number: ____________________

2. Please list the family member(s) or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY.**

NAME: ____Phone Number: ____________________
NAME: ____Phone Number: ____________________
NAME: ____Phone Number: ____________________
NAME: ____Phone Number: ____________________

3. Please **print** the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home *(Confidential Communications)*

Address____

4. Please **print** the telephone number or email address where you want to receive calls about your appointments, lab and x-ray results or other health care information, if other than yours

Contact Number: (____)____________________________

EmailAddress:____@__________________________

5. Can confidential message(s) (ie., appointment reminders) be left on your telephone answering machine or voicemail? YES:_____________ NO:_______________

I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices.

PATIENT NAME: ____*(Guardian if under 18 years old)*
(PLEASE PRINT)

_____________________________ _________________________ ____________________
PATIENT/PARENT SIGNATURE DATE OF BIRTH DATE