Lakewood Ambulatory Foot Center, Inc.

Name: _____ **Today's date:**_____
Last, First

Sex: M F

Marital Status: S M D W

Date of Birth _____ /_____ /_____ **SSN:** _____ /_____/_____

Address: _____

City, State, Zip:_____

Home Phone: _____ **Work Phone**: _____
Ok to call at work? ( ) Yes ( ) NO

Cell Phone: _____ **Alternate Phone**: _____

Email Address: _____
_____

Primary Insurance Co: _____ **Policy number**_____

Policy Holder Name: _____ **Date of Birth** _____

Address: (if different) _____

<u>Who is responsible for medical bill if not paid by your insurance?</u>

Name: _____ **Phone**: _____
Address: _____
_____

Emergency Contact: _____**Phone:** _____

Primary Dr:_____ **Last Visit**: _____
Location: _____

How did you hear about us, or whom may we thank for sending you to our office? _____

Previous Foot Doctor: Y N if yes who: _____

What is your chief foot complaint: _____

_____

Shoe Size_____

Race:
_____ American Indian or Alaska Native
_____ Asian
_____ African American
_____ Native Hawaiian or Pacific Islander
_____ Hispanic or Latino
_____ Caucasian (White)
_____ Other

Smoking Status: (Check one)
_____ Current every day smoker
_____ Current some day smoker
_____ Former Smoker
_____ Never Smoker
_____ Smoker, current status uknown
_____ Unknown

Preferred Language: _____

Height: _____ **Weight**: _____ **Pulse**:_____

Last Blood Pressure: _____ /_____

Allergies: (check all that apply)

( ) Aspirin ( ) Morphine ( ) Tapes/Adhesives
( ) Codeine ( ) Novocain ( ) Hay Fever
( ) Demerol ( ) Penicillin ( ) Iodine
( ) Sulfur ( ) Foods_____ ( ) Other_____
() *No known allergies*

SOCIAL HISTORY:

( ) Alcohol _____ ( ) Other _____ ( ) Recreational Drugs

( ) Smoker _____PPD ( ) Exercise ( ) None of these

DO YOU HAVE ANY OR HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING:

( ) Acid Reflux	( ) Anemia	( ) Anxiety
( ) Asthma	( ) Back Problems	( ) Bleeding Problems
( ) Bronchitis	( ) Cancer_____	( ) Circulatory Problems
( ) Depression	( ) Diabetes - type 1 or 2	( ) Eczema
	( ) Insulin or ( ) oral medication controlled	
( ) Epilepsy	( ) Fainting Spells	( ) Frequent Infections
( ) Glaucoma	( ) Gout	( ) Heart Conditions
( ) Heart Attack	( ) HIV/AIDS	( ) Hepatitis
( ) Hypertension	( ) Irritable Bowel Syndrome	( ) Arthritis
( ) Emphysema	( ) Kidney Disease	( ) Lupus
( ) Osteoporosis	( ) Pace Maker	( ) Parkinson's disease
( ) Phlebitis	( ) Polio	( ) Psoriasis
( ) Seizures	( ) Sciatica	( ) Stomach Ulcers
( ) Stroke	( ) Thyroid	( ) Tuberculosis
( ) Vascular Disease	( ) Other_____	

Prior Surgeries and Dates: _____

_____

_____

Family History: ( ) Diabetes ( ) Cancer ( ) Strokes ( ) Heart Disease

( ) Other _____

List ALL Medications You Are Currently Taking:
(or provide a list)

Pharmacy (If Known):_____

Name of Medication: _____

_____

*** Please write any additional information that you believe we should know below***

Signature: _____ Date: _____

AUTHORIZATION TO TREAT:

Patient Name (print): _____

I hereby give my permission to Stephen Smik, DPM to administer treatment and perform such minor operative procedures as may be deemed necessary in the diagnosis and treatment of my foot conditions. I understand that if my insurance company denies or refuses payment for any services rendered by Dr. Smik that I or the responsible party is liable for the payment of all unpaid balances.

Signature_____ **Date** _____

MEDICAL INSURANCE RELEASE AUTHORIZATION:

In order for us to submit a claim for services covered under your insurance policy, we must have your authorization to release medical information to your insurance carrier. Please read the following statement:

I authorize Dr. Stephen Smik and to whomever he designates to furnish my insurance company (or medicare) with all the necessary information regarding my present illness or injury. I also authorize payment of medical benefits to Dr. Stephen Smik, and/or Lakewood Ambulatory Foot Center, Inc. for medical supplies or services provided, with the understanding that any overpayment will be reimbursed to me promptly. A photocopy of this authorization shall be considered as effective and valid as the original.

Printed Name: _____

Signature: _____ **Date:** _____

Signature of Parent or guardian: _____

Patient Payment Policy

Thank you for choosing our practice. It is our belief that establishing a written financial policy is mutually beneficial to all parties. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing excellent healthcare services to our patients.

We participate with many insurance plans. Each insurance plan has different benefits for you as well as different financial obligations. Not all insurance policies cover all services. It is ultimately your responsibility to check with your insurance company to determine covered benefits.

The following are our policies relative to financial responsibility:

- **New patients must present an insurance card and photo identification.** New patients without insurance card(s) will be considered a cash account. Payment is due at time of service. Please present your insurance card(s) at each visit to our office.
- **Payment is expected at the time services are rendered.** This includes copays, deductibles and coinsurance, as well as payment for any non-covered or over the counter items.
- You may be charged a no-show fee of $25.00 for any appointments missed, not cancelled or rescheduled with at least 24 hours notice.
- Prior balances on your account must be paid in full within 60 days unless other arrangements are made **in advance and in writing** with office manager.
- Accounts may be turned over to collection agency for any balances past due 60 days or more.
- A service charge of $20.00 will be assessed for returned checks, refilling of insurance due to incomplete or *incorrect information given at the time of the appointment or for accounts turned over to collections.*
- I understand that I will be legally responsible for all collections costs associated with the collection of this account including court costs, reasonable attorney fees, and all other expenses incurred with collection if I default on any unpaid balance.
- In the case of services provided to patients under the age of 18, the parent, guardian or legal representative that initiates the services for the minor will be responsible for payment. We do not bill another individual or estranged spouse for payment.

I hereby authorize Lakewood Ambulatory Foot Center to file all medical claims with any and all insurance in which we participate. I hereby authorize payment of insurance benefits to me be made to Lakewood Ambulatory Foot Center. I authorize release of any information related to any claims to all my insurance companies or other relative parties. I further understand that if my insurance company denies any or all medical services as "non-covered", "coverage terminated", "pre-existing", or "not a covered member", I will be responsible for full payment within 30 days of said denials, or within 30 days of the first billing statement sent by our office following the receipt of said denial(s). I understand that we will not file any claims for non-covered or over the counter items.

I fully understand the above policies and agree to be financially responsible for any and all incurred charges resulting from medical services rendered.

Upon arrival at our office, you will be asked to read and sign this form prior to receiving any services. A copy of the signed form will be provided to you.

Signature _____ **Date** _____