

PATIENT NAME: _____

PATIENT FINANCIAL POLICY

YOUR INSURANCE POLICY (COVERAGE) IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR INSURANCE POLICY BENEFITS PERTAINING TO FOOT CARE TREATMENT (COVERAGE).

- If you are not insured [have no insurance or one that is not accepted by Dr. Kuzyk's Office], your full payment is due at the time of your service. Cash, Checks and Credit Cards are accepted.
- You are responsible for all authorizations / referral needed to see the doctor.
- If your insurance requires a referral /authorization and you do not have one, you will be expected to pay the office visit charges before seeing the doctor and any other charges (X-rays, Surgery, Biopsies, etc.) before leaving the office. Cash, Checks and Credit Cards are accepted
- **Payments / Deductibles / Co-payments are due at the time of your office visit.**
- If you have insurance you are responsible to pay your part of the office charges that your insurance does not pay, e.g. Co-pays, Non-covered services, denied services, Deductibles, etc.
- If it is an un-assigned claim, full payment will be due on the day of your visit. Cash, Checks and Credit Cards are accepted.
- If your insurance company does not pay within 90 days of billing them, you will be responsible to pay your bill.
- If your health plan / insurance company determines that the services are "not covered" or "not authorized" you will be responsible for the complete charge. Cash, Checks and Credit Cards are accepted.
- There is a **\$30.00 CHARGE FOR EACH RETURNED CHECK.** If it occurs twice, we will provide care **ONLY ON A CASH BASIS**, no checks or charge cards.
- Past due accounts will be submitted to a collection agency if no payment has been received within 30 days of the date on the statement. Once the account is turned over to the collection agency you will need to contact them to pay your bill and you will be responsible to them for the past due amount and any fees they charge. **DO NOT SEND THE PAYMENT TO DR. KUZYK ONCE THE COLLECTION AGENCY HAS YOUR ACCOUNT.**

I understand that I am responsible for the payment of all charges whether or not they are paid in full or in part by the insurance company.

PATIENT NAME AND SIGNATURE: _____ DATE: _____

RESPONSIBLE PARTY'S SIGNATURE: _____ DATE: _____

PATIENT NAME: _____

PATIENT'S CURRENT FOOT / ANKLE PROBLEM

What is your toe/foot/ankle problem for today? _____

Family Doctor: _____ Phone Number: _____

Address: _____

Current Weight: _____ Height: _____ Shoe Size: _____ Type of shoes worn: _____

PATIENT'S MEDICAL HISTORY

MEDICATIONS / VITAMINS PATIENT TAKES & DOSAGES:

OR [] SEE ATTACHED LIST OF MEDICATIONS / VITAMINS THE PATIENT IS CURRENTLY TAKING.

ALLERGIES TO MEDICINE, FOOD OR ENVIRONMENT: [] NO, [] YES, IF YES WHAT IS THE PATIENT ALLERGIC TO & THE REACTION THEY GET: _____

[] Anemia, [] Arthritis, [] Asthma, [] Bleeding – what caused it? _____

[] Cancer, [] Circulation at type and what treatment: _____

[] Depression, [] Diet Problems, [] Diabetes: How long? _____ Type: _____

Daily Blood Sugar Level: _____ Last A1C reading: _____

[] Epilepsy, [] Fainting, [] Gout, [] Gallbladder Problems, [] Headaches – What type: _____

[] Heart Disease - What type _____ [] Had Heart Problems, [] Hearing Problems,

[] High Blood Pressure or had it, [] Hormone [] Joint Pain, [] Kidney Problems – Type: _____

[] Liver Problems – Type: _____, [] Nerve Problems, [] Mouth Problems, [] Scarring Problems,

[] Shortness of Breath, [] Spinal Pain, [] Stomach Problems, [] Bowel Problems, [] Stroke, [] Swelling,

[] Thyroid Problems, [] Tuberculosis, [] Vision Problems [] Hepatitis – Type: _____ [] HIV +/- AIDS

[] Take Immuno Suppressants, [] Numbness in the [] Legs, [] foot, [] toes, [] Burning, [] Tingling,

[] Itching, [] Night Pain, [] Leg Cramps: [] at night, [] day time, [] walking, [] Calf Pain: [] at rest, [] walking

[] Any Other Medical Problem: _____

SERIOUS ILLNESS: [] No, [] Yes – What? _____

MAJOR OR MINOR SURGERIES: [] No, [] Yes - When, What and Where: _____

HOSPITALIZATIONS: [] No, [] Yes - When, What and Where: _____

Check if patient has any of these: [] Artificial Joints, [] Heart Implants, [] Pace Maker, [] By-pass surgery, [] Organ Transplant

PATIENT'S NAME: _____

PATIENT'S SOCIAL HISTORY: CHECK WHICH ONES PERTAIN TO THE PATIENT

Are you pregnant? No Yes –How many months? _____ Due date: _____ No Yes Breastfeeding

Smoker: No Yes What? _____, How many per day? _____ For how long? _____

Quit - How long ago? _____ Fill out the above for when you were a smoker.

Alcohol: No Yes What? _____, How much? _____ How often? _____

Quit - Why? _____ Fill out the above for when you were a drinker.

Drugs (e.g. Marijuana) etc., No Yes What? _____, How much? _____

How often? _____ Quit - How long ago? _____

FAMILY MEDICAL HISTORY: Check and tell which one in your family has it. (BLOOD RELATED)

Arthritis _____, Bleeding Problems _____, Diabetes _____

Cancer _____, Heart Problems _____, High Blood Pressure _____

Mental / Emotional Disorder _____, Stroke / Circulation Problem _____

Similar Foot Problems _____, what problem _____

OTHER INFORMATION YOU FEEL THE DOCTOR NEEDS TO KNOW ABOUT:

By signing this form, I certify that the above information is true and correct to the best of my knowledge. I **AUTHORIZE** Dr. Kuzyk and/or his staff to:

DISCUSS MY MEDICAL CONDITION AND TREATMENT WITH OTHER MEDICAL PROVIDERS

DISCUSS MY MEDICAL CONDITION AND TREATMENT WITH MY INSURANCE COMPANY

CHECK BOX IF YOU WILL ALLOW THE ABOVE: YES NO

DISCUSS MY MEDICAL CONDITION AND TREATMENT WITH MY FAMILY MEMBERS / RESPONSIBLE PARTY (PERSON).

CHECK BOX IF YOU WILL ALLOW THE ABOVE: YES NO

This will allow improvement of my medical care and payment of such services.

Signature of Patient: _____ Date: _____

Signature of Responsible Party: _____ Date: _____