PLEASE PRINT THE FIVE PAGES, BRING THEM WITH YOU TO THE APPT. BRING PICTURE I.D.AND INS.CARD

PATIENT INFORMATION [FILL OUT ALL THE INFORMATION / SPACES]

PATIENT NAME: _____ _____ _____ [ ] Male [ ] Female
[Last] [First] [Middle Initial]

Home Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Date of Birth: ___/___/_____ Age: _____ [ ] Single [ ] Widowed [ ] Married

Person to contact in case of an emergency: Name: _____ Relationship: _____ Phone #: ___-___-_____

Referred by: _____

PLEASE FILL OUT FOR THE ELECTRONIC MEDICAL RECORD INITIATIVE:

Hispanic [ ], Non-Hispanic [ ], Ethnicity: _____ Race: _____Preferred Language: _____

HEALTH INSURANCE INFORMATION

Primary Insurance:

PRIMARY SUBSCRIBER NAME: _____ Date of Birth: ____/_____/_____

Relationship to patient: _____ Insurance Company's Name: _____

Insurance Company's Address: _____

Insurance Company's Phone #: ____/____/_____ ID# _____ Group/ Plan #: _____

Secondary Insurance:

PRIMARY SUBSCRIBER NAME: _____ Date of Birth: ____/_____/_____

Relationship to patient: _____ Insurance Company's Name: _____

Insurance Company's Address: _____

Insurance Company's Phone #: ____/____/_____ ID# _____ Group/ Plan #: _____

- **I AUTHORIZE THE USE OF "ASSIGNMENT OF BENEFITS" OR A COPY OF THIS SIGNATURE AS MY ORIGINAL SIGNATURE FOR ALL INSURANCE SUBMISSIONS.**
- I hereby authorize Dr. Kuzyk or his office to release any and all information concerning my examination and treatment to my insurance carrier to secure payment on my behalf.
- I hereby assign all medical and surgical benefits to which I am entitled to Dr. Kuzyk so that the insurance company will pay him directly.
- I authorize Dr. Kuzyk /staff to provide information to other health care providers or obtain health information so I/Dependent will have the best health care.
- Dr. Kuzyk's office follows the standard government guidelines of patient privacy under the H.I.P.P.A [health information patient privacy act] regarding my personal and medical information. I acknowledge that I am aware of these standards and guidelines and understand them. I am also aware that a copy of these guidelines and standards will be provided to me upon my request. By signing below I agree to the H.I.P.P.A. guidelines.
- By signing, I have read and understood the above.

_____ _____

Patient's Signature or if under 18 Authorized Representative / Parent Date

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.
- **THERE IS A $75 CHARGE FOR NOT SHOWING UP FOR AN APPOINTMENT WITHOUT CALLING TO CANCEL WITHIN 24 HRS.**

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: _____

CONSENT TO RECEIVE VOICE MESSAGE, TEXT MESSAGING OR EMAIL MESSAGE

PLEASE CHECK ONE OF THE BOXES:

[ ] I understand that the information sent to me via email and / or text or voice message from person's at Dr Kuzyk's office will **NOT BE SENT SECURELY AND WILL NOT BE ENCRYPTED.** I understand the risks associated with that including, but not limited to, that of my **PERSONAL HEALTH INFORMATION MAY BE READ BY AN UNINTENDED THIRD PARTY.** I have been notified of the risks. I understand said risks and **I STILL PREFER TO RECEIVE PROTECTED HEALTH INFORMATION VIA UNSECURE COMMUNICATIONS VIA VOICE, TEXT OR EMAIL.**

I understand Dr Kuzyk's office and staff are **NOT RESPONSIBLE** for any unauthorized access of my protected health information communicated by way of encrypted email and text and that I bear the risks.

THE PHONE NUMBER (S) TO BE USED ARE AS FOLLOWS

CELL NUMBER: _____

HOME PHONE NUMBER: _____

EMAIL: _____

[ ] I DO NOT GIVE PERMISSION TO LEAVE A TEXT, VOICE OR EMAIL MESSAGE TO ME BY DR KUZYK OR HIS OFFICE REGARDING ANY MEDICAL INFORMATION. **IT IS ONLY OK TO LEAVE MESSAGE FOR AN APPOINTMENT REMINDER.**

_____ _____

PATIENT /OR RESPONSIBLE PERSON SIGNATURE DATE

_____

PATIENT'S PRINTED NAME

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: _____