Patient Information (PLEASE PRINT)

Name____ Date of Birth_______________ Age_____

Social Security #___________________________ Marital Status: Married Widowed Divorced Separated Single

If patient is under 18 or not able to make decisions for themselves please complete

Guardian/Parent Name________________________ Guardian/Parent SS#_______________ Do you have Power of Attorney?___

Guardian/Parent's Address____

Guardian/Parent's Phone ____________________

Patient Address____

Home Phone____________________ Work Phone____________________ Cell Phone_______________________

Email____________________________________ (for appointment reminders only- **no reminder calls available**)

Is it ok to leave a generic message at your home or cell #? ___yes ____no

(No medical information will be shared with another person or left on your machine/voicemail)

Next of Kin Name and Phone____

May we contact them in case of an emergency?____yes______no

Your Employer's Name____

Your Employer's Address____

How did you hear about us? ____

Primary Insurance Company Name__________________________________

ID#____ Group #_______________________

Name of the person who owns this policy _____________________________ DOB___________ SS#__________________

Policy owner's relationship to patient (please circle) SELF SPOUSE PARENT/GUARDIAN

Secondary Insurance Company Name____

ID#____ Group #_______________________

Name of the person who owns this policy _____________________________ DOB___________ SS#__________________

Policy owner's relationship to patient (please circle) SELF SPOUSE PARENT/GUARDIAN

We will happily file your insurance for you. Please remember that you have a contract with your insurance carrier. We are not a party to that contract nor do we have any information regarding your contract with your insurance provider. By signing below you give Dr. Pinsky permission to file your insurance and accept payment from them on your behalf. You will be responsible for any balance unpaid by your insurance.

Signature____ Date____________________

Financial Policies (PLEASE PRINT)

Name____ Date of Birth______________

To preserve the best possible relationship with you, our patient, and to prevent any misunderstanding, we hope the following explanation of our office policies is helpful.

- Payment is expected at the time of receipt for any non-covered supplies such as arch supports, surgical shoes, pads, etc. We cannot bill you or your insurance carrier for these supplies.
- Payment is expected at the time of service for **Routine Foot Care** which is defined as the **trimming of corns, calluses and toenails**. We cannot bill insurance for this non-covered service for both non-diabetic and diabetic patients. **As this is a non-covered service, it <u>cannot</u> be combined with a medical visit.**
- All copayments are due at the time of service. No exceptions.
- All patient balances must be paid-in-full before seeing Dr. Pinsky. Delinquent accounts will be turned over to our collection agency. Once the agency has an account, it will accrue a collection charge and interest. **Patients will need to contact the collection agency to discuss their bill and make any payments to them.**
- We gladly bill your insurance company for all medically necessary services; however, we cannot guarantee all services will be paid for by your insurance carrier. **You** will be responsible for any charges not paid by your insurance carrier. Any questions regarding what's a covered service or unpaid balances should be directed to your insurance provider. We are not able to get this information for you. Please remember to bring your insurance card and photo i.d. to every appointment. Without them, you cannot be seen. **You** are responsible for keeping your insurance information up-to-date.
- Patients who fail to cancel **24 hours** prior to their appointment time may be billed for the missed appointment. **There is a $45.00 fee for missed office visits and a $65.00 fee for missed procedures/surgeries and diagnostic tests**. These rates are subject to change at any time. Please call if you are running late for your appointment, this gives us a chance to work you back into the schedule; otherwise you may have to reschedule. Medicaid recipients who fail to show up on time or at all for a scheduled appointment may be immediately dismissed from practice.
- **There is a $25.00 returned check fee** for all returned checks for any reason. If a returned check and fee does not get paid within 5 business days, it will be forwarded to our attorney for legal action and collection.
- **There is a charge for special letters and forms**. Please request in advance and supply your permission in writing that we can share this information with the requesting party. All fees must be paid upon pick-up.
- You may access your medical record through our internet patient portal with Practice Fusion. Ask how to enroll.

PLEASE SIGN AND DATE AFTER READING ALL STATEMENTS:

I have read, understand and agree to the above policies.

I have read or been given the opportunity to read the Notice of Privacy Practices and I understand my rights under this Notice.

Dr. Pinsky and/or his staff may release my medical information to the following person(s) until I notify you otherwise, in writing.

Name__________________________________ Relationship____________________

Name__________________________________ Relationship____________________

Please Print Your Name & Relationship (if patient unable to sign for themselves)_____________________________________

Signature____ Date_____________

Medical Information (PLEASE PRINT)

Name____ Date of Birth________________ Height_________ Weight________lbs

What is your chief foot complaint?____________________________________ How Long? __days __weeks __months __years

Please indicate if you have ever had, or been treated for the following:

__ Diabetes	__ Heart Disease	__ Ulcers	__Anemia
__ High Blood Pressure	__ Heart Attack	__ Acid Reflux	__ Prolonged Bleeding
__ Stroke	__ Arrhythmia	__ Stomach Problems	__ Poor Circulation
__ High Cholesterol	__ Heart Murmur	__ Hiatal Hernia	__ Leg Pain When Walking
__ Asthma	__ Chest Pain	__ GI or Rectal Bleeding	__ Varicose Veins
__ Tuberculosis	__ Blood Clots	__ Bowel Disorder	__ Pacemaker
__ Emphysema	__ Headaches	__Epilepsy/Seizures	__ Thyroid Disease
__ Shortness of Breath	__ Glaucoma	__Tremors	__ Muscle Disease/Polio
__ Anxiety	__ Hearing Problems	__ Numbness/Burning	__ Kidney Problems
__ Depression	__Osteoarthritis	__ Alzheimer's	__ Bladder Problems
__ Drug Dependence	__ Rheumatoid Arthritis	__ Spine Injury	__Prostate Problems
__ Alcohol Dependence	__Gout	__ HIV	__Hepatitis/Liver Disease
__ Psychiatric Care	__Cancer (type(s)__________________________)		__ Amputation (where______________)

Other medical conditions not listed above____

Please list all medications, along with their dosages or attach a list

____

____

____

Please list any drug or food allergy/type of reaction____

Please list any surgeries____

Do you smoke? __yes __no (how many packs per day?___) Do you drink alcohol? __yes __no (__socially __daily __ heavy)

(For women) Are you pregnant? __yes __no Family Med History____

Family Doctor/Location____ Phone __________________________

Pharmacy Name/Location____ Phone __________________________

I give my permission to Dr. Marc Jay Pinsky to administer treatment and to perform such procedures/diagnostic tests as may be deemed necessary in the diagnosis and treatment of my foot condition. I also authorize the disclosure of medical and insurance information to assist in processing my insurance claim(s) and to communicate with treating physicians.

Signature____ Date____________________