Lakeside Foot & Ankle Center

Karsten Weber, DPM * Alex Stirling, DPM* Nicole Hancock, DPM

Patient Information

Name: _____ Date of Birth: _____ Sex: ___

Street Address: _____ City: _____ State___ Zip_____

Mailing Address (if different) _____City: _____State ____ Zip ____

Phone # _____ Cell Phone # _____Email _____

Patient's SS# _____ Married __ Single __ Widow(er) __ Divorced __

Preferred Language _____ Race _____ Ethnicity _____

Patient / Responsible Party Information

Employer _____ Occupation_____

Employer's address _____ Phone # _____

Insured's name _____ Occupation _____

Insured' SS# _____ Employer _____

Insured's Date of Birth _____ Insured's relationship to patient _____

Emergency Contact

Name _____ Relationship _____

Phone# (Home) _____ (Work) _____ (Cell) _____

*******REFERRED BY:_____Friend/Family, Online, Advertising, Physician, Insurance***

I give my consent allowing your office to discuss my medical information with this person. (YES) ___ (NO)___
If not, do you have an alternate person that you consent to allowing discussion of your medical information? Name: _____Relationship_____Phone#_____

Patient Signature _____ Date _____

I have read the HIPAA Privacy Notice and understand my rights.

Signature _____ Date _____

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/ or treatment of my feet and / or ankles.

Signature of Patient or Responsible Party **Date**

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Patient's Name _____ DOB _____

MECICAL HISTORY

Family Physician _____ Date last seen _____

Family Physician Phone# _____ Pharmacy & Phone # _____

Other Specialist Drs _____

Height _____ Weight _____ Age _____

Medical History_____

Are you Diabetic (YES) _____ (NO) _____ Are you on Blood Thinners (YES) ____ (NO) _____

Has the patient had a flu shot (YES) ____ (NO) ____ If no why: (allergy)____ (declined) ____ (other)____

If yes: (Date) _____ (Location) _____ (Phone #) _____

Patients 65 and older: Has the patient been vaccinated for pneumonia (YES) ____ (NO) ____

(Date) _____ (Location) _____ (Phone #) _____ If no why: _____

FOR DIABETICS ONLY: ***Eye Exam (YES) (NO) If YES, WHEN: WHERE:***

What was your last Hemoglobin A1c Value and when and where was it last performed?

Value Date performed Where performed

Do you use: CANE _____ WHEEL CHAIR/SCOOTER _____ WALKER _____

Surgical History: _____

_____

Family Medical History: _____

_____

****

I hereby sign for release of my medical records pertaining to the above information to be collected from: _____

so they may be a part of my record here at Lakeside Foot and Ankle Center.

Patient Signature_____ Date _____

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Patients over the age of 65:

Do you have a Living Will / Medical Power of Attorney? (YES) ___ (NO) ___

If NO, why not _____

If YES, who _____

Social History

Do you currently smoke or use tobacco products (YES) ____ (NO) ____

Circle all that apply (cigarettes / chew / dip tobacco / pipe /cigars/ recreational drug / marijuana / other (_____) How much _____ How long have you used the above ____ yrs.

If you quit, how long ago did you quit? _____

Alcohol Use (YES) ___ (NO) ___ How much and how long used _____

Illegal Drugs (YES) ___ (NO) ___ Drug history _____

Exercise (YES) ___ (NO) ___ If yes, how often _____

Retired (YES) ___ (NO) ___ If employed, where _____

What brings you here to see us today? _____

_____

_____

_____

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Patient's Name _____ Number _____

CURRENT MEDICATIONS

Name	Strength	# / Day	Allergies

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Assignment and ReleaseI, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Karsten S. Weber DPM, Alexander A. Stirling DPM, and or Nicole D. Hancock DPM, doing business as Lakeside Foot & Ankle Center all insurance benefits, if any, otherwise payable to us for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____

Relationship to patient _____

Date _____

Medicare Authorization

I request that payment of authorized Medicare benefits be made on my behalf to Karsten S. Weber DPM, Alexander A. Stirling DPM, and / or Nicole D. Hancock DPM, doing business as Lakeside Foot & Ankle Center for any services furnished me. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services and supplies. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Signature _____

Date _____

Self Pay

I understand that I am financially responsible for all charges and that payment in full is expected at the time treatment is rendered, unless payment arrangements have been made in advance.

Signature _____

Date _____

Lakeside Foot & Ankle Center

Advance Notice to People with Medicare
That Medicare Will Not Pay for Certain Foot Care Services and Items

When you receive foot care services and items that are not Medicare benefits, you are responsible to pay for them personally or through any other insurance that you may have. Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits. When services or items are **not Medicare covered benefits,** Medicare **will not pay** for them.

The purpose of this advance notice is to help you make an informed choice about whether or not you want to receive these foot care services or items, knowing that you will have to pay for them yourself. We do not send claims to Medicare for foot care services or items that are always excluded from Medicare coverage.

Before you make a decision, you should read this entire notice carefully.

The Medicare program does not cover most routine foot care and flat foot care. The Medicare law clearly excludes coverage for services in connection with "the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care". The Medicare law clearly excludes coverage for services in connection with "treatment of flat foot conditions and the prescription of supportive devices therefore" or with "the treatment of subluxations of the foot". Providers may not be required to submit Medicare claims for such services.

A narrow **exception** permits coverage of some foot care services when certain conditions result in severe circulatory problems or areas of diminished sensation.

The Medicare program does not cover most orthopedic shoes or other foot supports (orthotics). The Medicare law clearly excluded coverage for services in connection with "orthopedic shoes or other supportive devices for the feet".

A narrow **exception** permits coverage of special shoes and inserts for certain patients with diabetes.

For people with Medicare, this means that Medicare will not pay for most routine foot care, flat foot care, orthopedic shoes, or orthotics, because they are not Medicare covered benefits. Payment for these excluded foot care services and items is your responsibility.

If you have any additional questions concerning Medicare coverage for foot care services or items, you can contact Medicare at 1-800-MEDICARE (1-800-633-4227)

This notice is published by American Podiatric Medical Association, 9312 Georgetown Road, Bethesda MD 20814-1621. The Centers for Medicare & Medicaid Services has reviewed this APMA notice about foot care coverage and confirmed the accuracy of its content. This notice is only a general summary of foot care exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations and rulings.

Patient Signature _____ Date _____

Lakside Foot & Ankle Center

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

*As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

*Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.

*Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

*We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/ co-insurance/deductible at the time of service.

*If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

* All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered" or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

*You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

*For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

*There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

*Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

*There is a service fee of $25 for all returned checks. Your insurance does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____**Date** _____

Witness Signature: _____ Date _____

Printed Name of Witness: _____

_____ **Patient initials to indicate copy received.**