

LAKESIDE FOOT & ANKLE CENTER

Karsten Weber,DPM Nicole Hancock, DPM Alexander Stirling, DPM

Patient Information

Name: _____ Date of Birth: _____ Sex: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Mailing Address (if different): _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Patient's SSN: _____ Married Single Widow(er) Divorced
Occupation: _____
Preferred Language: _____ Race: _____ Ethnicity: _____

Patient / Responsible Party Information

Insured's Name: _____ Insured's SSN: _____
Insured's Date of Birth: _____ Insured's relationship to patient: _____

REFERRED BY: Friend/Family Physician Google Facebook Insurance Other

Emergency Contact

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
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 allow us to discuss your medical information with? Name: _____ Phone: _____ Relationship: _____

Patient Signature: _____ **Date:** _____

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

Patient 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.

Patient or Responsible Party Signature: _____ **Date:** _____

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Patient Name: _____ Date of Birth: _____

Medical History

Primary Care Physician: _____ Date Last Seen: _____

PCP Phone Number: _____ Pharmacy: _____

Other Specialist Doctors: _____

Height: _____ Weight: _____ Age: _____

Are you diabetic? YES NO Are you on blood thinners? YES NO

Have you had the flu shot? YES NO

If NO, why? Allergy Declined Other: _____

If YES, Date: _____

Medical History: _____

Surgical History: _____

Family Medical History: _____

Patients 65 and older: Have you been vaccinated for Pneumonia? YES NO If YES, Date: _____

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

If No, why not? _____

If YES, who? _____

Do you use: Cane Wheelchair/Scooter Walker

FOR DIABETICS ONLY: Have you had an eye exam? YES NO

What was your last Hemoglobin A1c value: _____ Date performed: _____

I hereby authorize the release of my medical records pertaining to the above information to be collected from: _____ so that they may be made part of my record here at Lakeside Foot & Ankle Center.

Patient or Responsible Party Signature: _____ **Date:** _____

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Social History

Do you currently smoke or use tobacco products? YES NO

If YES, circle all that apply. Cigarettes/Vape Dip tobacco Pipe Cigars Marijuana Recreational Drugs

If YES, how much and often do you use tobacco products? _____

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

Alcohol use YES NO How much and how often? _____

Illegal drugs YES NO If YES, how often? _____

What brings you in to see us today? _____

ALLERGIES

Please include medication and nonmedication allergies

CURRENT MEDICATIONS

Please include name, strength, and frequency

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Assignment and Release

I, 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.

Patient or Responsible Party Signature: _____ **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 to 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.

Patient or Responsible Party 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.

Patient or Responsible Party Signature: _____ **Date:** _____

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Advance Notice to Patients with Medicare

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 healthcare costs. Medicare only pays for the 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” or with “the treatment of subluxations of the foot.” Providers may not be required to submit Medicare claims to 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 excludes coverage for services in connections 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 are 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 or Responsible Party Signature: _____ Date: _____

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Patient Financial Policy

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

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements are made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We 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 amount of time, 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 copay, coinsurance, and/or deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have an 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 for any service rendered. Patients are encouraged to contact their insurer for clarification of benefits prior to services being 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 to this office.
- There is a service fee of \$25 for all returned checks. Your insurance does not cover this fee.

Patient or Responsible Party Signature: _____ **Date:** _____

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

Witness Signature: _____ **Date:** _____

Printed Name of Witness: _____

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at Lakeside Foot & Ankle Center, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Lakeside Foot & Ankle Center to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

Signature of Patient

Printed Name of Patient

Date