

**Sarasota Foot Care Center, PA**

Please print clearly

Account Number \_\_\_\_\_

Name \_\_\_\_\_  
(Last) (First) (Middle)

Billing Address \_\_\_\_\_  
\_\_\_\_\_  
City State Zip

Northern Address \_\_\_\_\_  
\_\_\_\_\_  
City State Zip

Main Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender:  Female  Male Social Security # \_\_\_\_\_

Email Address \_\_\_\_\_

<b>Race:</b>	<b>Ethnicity:</b>	<b>Smoking:</b>	<b>Marital Status:</b>	<b>Language:</b>
<input type="checkbox"/> Caucasian	<input type="checkbox"/> nonHispan	<input type="checkbox"/> Daily	<input type="checkbox"/> S	<input type="checkbox"/> English
<input type="checkbox"/> Black	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Some days	<input type="checkbox"/> M	<input type="checkbox"/> Spanish
<input type="checkbox"/> Asian		<input type="checkbox"/> Former	<input type="checkbox"/> D	<input type="checkbox"/> Other _____
Other _____		<input type="checkbox"/> Never	<input type="checkbox"/> W	

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Responsible party (for minor) \_\_\_\_\_ Relationship \_\_\_\_\_  
(Last) (First)

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

Name of policy holder \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Is Insurance through employer?  Yes  No Yours or Spouse? \_\_\_\_\_

Pharmacy \_\_\_\_\_ Location \_\_\_\_\_ Phone # \_\_\_\_\_

IF WE CANNOT VERIFY YOUR INSURANCE BENEFITS BEFORE YOU ARE SEEN, YOU WILL BE ASKED FOR PAYMENT IN FULL

IF THIS VISIT IS RELATED TO A WORK INJURY, AUTO ACCIDENT, OR INVOLVES ANY TYPE OF LIGATION, PLEASE NOTIFY THE RECEPTIONIST IMMEDIATELY

I hereby authorize the release of any medical information necessary for processing claims and payment of medical benefits to myself or the party who accepts assignment (lifetime signature). I understand that, as the patient receiving medical treatment, I am responsible for payment regardless of insurance coverage or litigation.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Responsible party)

Account Number: \_\_\_\_\_ SARASOTA FOOT CARE CENTER, PA

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Date \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe size \_\_\_\_\_ Date of onset of symptoms \_\_\_\_\_

Reason for visit \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Medical Doctor \_\_\_\_\_ Date last seen \_\_\_\_\_ Former Podiatrist \_\_\_\_\_

**Medical History** (check only those items that apply)

- Anemia
- Arthritis
- Asthma
- Autoimmune disease
- Blood disease
- Cancer, type: \_\_\_\_\_
- Charcot joint
- CVA (stroke)
- Depression
- Diabetes Type 1 or 2 \_\_\_\_\_ diet/oral/insulin \_\_\_yr
- Eye pathology
- Gastric reflux
- GI Ulcers
- Heart disease
- High blood pressure
- High cholesterol
- Hypert thyroidism
- Hypothyroidism
- Kidney disease
- Leg cramps/numbness
- Liver disease
- Mitral valve prolapse
- Peripheral neuropathy
- Peripheral vascular dis
- Varicose veins
- Osteoporosis

Other Medical problems (please list) \_\_\_\_\_

Have you received the flu vaccine this season? Yes No

Have you received the pneumonia vaccine? Yes No

**Surgical History** (check only those items that apply)

- Angioplasty
- Appendectomy
- Arterial by-pass
- Back surgery
- Breast biopsy
- Carotid artery sx
- Cataract
- Colonoscopy
- C-section
- D and C
- Endoscopy
- Foot surgery, type: \_\_\_\_\_
- Gall bladder sx
- Heart by-pass
- Heart catheter
- Hernia repair
- Hip replacement
- Hysterectomy
- Kidney removal
- Kidney stone sx
- Knee replacement
- Mastectomy
- Neck surgery
- Open heart sx
- Pacemaker
- Prostate surgery
- Tonsillectomy
- Venous ligation

Other Surgery (please list) \_\_\_\_\_

Medications (please list) \_\_\_\_\_

**Family History** (please circle if positive)

	<u>Diabetes</u>	<u>Heart disease</u>	<u>Cancer</u>	<u>High blood pressure</u>
<u>Mother</u>	yes	yes	yes	yes
<u>Father</u>	yes	yes	yes	yes
<u>Siblings</u>	yes	yes	yes	yes

**Current Activities and Social History** (please check)

- Alcohol (frequency) \_\_\_\_\_ Tobacco \_\_\_\_\_ ppd Date quit \_\_\_\_\_ Caffeine (type) \_\_\_\_\_
- Physical Activities \_\_\_\_\_

**Allergies** (please check)

- Novocaine
- Aspirin
- Codeine
- Penicillin
- Cortisone
- Adhesive tape
- Sulfa
- Other \_\_\_\_\_

**Review of systems** (filled out by nurse)

- Cardiovascular** hypertension / murmurs / chest pain / edema / claudication / ulceration / phlebitis / heart attack
- Gastrointestinal** jaundice / cirrhosis / hepatitis / gastric reflux / GI ulcers / nausea / vomiting
- Musculoskeletal** joint pain / joint swelling / muscle pain / poststatic dyskinesia / weakness / back pain
- Dermatologic** rash / bleeding / bruising / pruritis / hypertrophic nails / ulcer / skin infection / psoriasis
- Neurologic** paralysis / stroke / tics / tremors / seizures / tingling / numbness
- Allergic/immunologic** allergies / anaphylactic reactions / HIV / immunosuppressed / recurring infections **Tech** \_\_\_\_\_



## **Sarasota Foot Care Center, PA**

2000 Webber St., Suite 110, Sarasota, FL 34239 (941) 917-6232

Welcome to the office of Sarasota Foot Care Center, PA. Our Front Desk and Billing staff will be happy to assist you in answering any further questions you may have regarding this information.

**SELF-PAY PATIENTS** -- If you are uninsured, you are responsible for payment in full at the time of service, unless prior arrangements have been made with our Business Office at (941) 917-6232, Monday-Friday.

**MANAGED CARE (HMO/PPO/POS/EPO)** If we participate with your insurance, you are responsible for paying your co-payment and for obtaining any referrals/authorizations your plan may require at the time of service. We will verify your insurance and benefits. If your deductible has not been met, you will be responsible for payment at the time of service.

**MEDICARE PATIENTS** -- We accept assignment on all Medicare claims. As a courtesy we will also file your secondary insurance. If we have to file your secondary more than twice or have excessive difficulty collecting the secondary balance, that balance will be billed to you. We do not file tertiary insurance policies.

**NO FAULT/WORKERS COMP** -- We do not participate in No Fault/Workers Comp. Payment in full is expected at time of service, unless prior arrangements have been made.

**MEDICAID:** We do not participate with Medicaid. Payment in full is expected at time of service, unless prior arrangements have been made.

We accept cash, checks, MasterCard and Visa.

YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. It is customary to pay for services when rendered unless prior arrangements have been made.

**AUTHORIZATION OF TREATMENT/ASSIGNMENT OF BENEFITS:**

I hereby authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I hereby authorize my physician to release any information regarding my medical condition, including disability or employment related information concerning my claims for my insurance carrier(s), authorized agent(s) or attorney(s) for the purpose of validating and determining benefits payable in connection with my incurred medical expense. I understand that my authorized representative or I may receive a copy of this authorization request. I also authorize direct payment of benefits to my attending physician.

I have read and/or have been advised to read the entire Financial Policy outlined.

Patient/Guarantor \_\_\_\_\_ Date \_\_\_\_\_  
(signature)

Patient Name \_\_\_\_\_  
(please print)



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Acknowledgement of Receipt of Notice of Privacy Policies

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them, and that I understand the nature of these policies.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient (or Patient's Legal Representative)

**Important:**

Messages containing medical information may be delivered to me via (initial all that may apply):

\_\_\_\_\_ Work Phone

\_\_\_\_\_ Cell Phone

\_\_\_\_\_ Voice Mail

\_\_\_\_\_ Home Answering Machine

\_\_\_\_\_ Designated Family Member:

\_\_\_\_\_  
*Name of Designated Family Member*

\_\_\_\_\_ None of the above, Please relay information directly to me.

# Sarasota Foot Care Center, P.A

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Robert Frimmel, DPM      Craig Conti, DPM  
Candice Kepich, DPM      Matthew Liwski, DPM

## Advance Planning Attestation Statement

I, \_\_\_\_\_, hereby attest that I have engaged in advance planning for my healthcare decisions. I understand the importance of expressing my wishes regarding medical treatment and end-of-life care in advance, particularly in situations where I may not be able to communicate my preferences.

I have taken the following steps to ensure my healthcare preferences are Known and respected:

- I have completed an advance directive document outlining my healthcare wishes, including preferences for life-sustaining treatments, resuscitation, and organ donation.
- I have discussed my advance directive with my designated healthcare proxy or decision-maker, ensuring they understand my preferences and are willing to advocate for them in the event I am unable to do so myself.
- I have provided copies of my advance directive to my healthcare providers, hospital, and any other relevant parties involved in my medical care.
- I have regularly reviewed and updated my advance directive as needed to reflect any changes in my healthcare preferences or personal circumstances.

By signing this statement, I affirm that I have completed advance planning for my healthcare decisions to the best of my ability, and I understand the importance of communicating my wishes to ensure they are honored.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_