Healthy Feet Podiatry

WE ARE VERY PLEASE TO HAVE YOU WITH US! Please answer the following questions to help us become acquainted.

Date_____ **How did you hear about us? (Be Specific Please)** _____

First Name _____ Last Name _____ Middle _____ Age _____ Birthdate ____/____/_____

Sex: M F SS# _____ HT. _____ WT. _____ Employer Name _____

Home Address _____ City _____ State _____ Zip _____

Home# ( )_____ Cell# ( )_____ **EMAIL:** _____

Name of Parent (if minor) _____ Emergency Contact, Relationship &Number_____

Primary Care Physician Name _____

PCP Phone # _____ **Date last seen by PCP** _____

Pharmacy/Location_____ Phone: _____

MEDICATIONS: **NONE** ☐ **LIST ATTACHED** ☐

PERSONAL HISTORY- PAST MEDICAL HISTORY If you have, or have had, any of the following, please check:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Rheumatic Fever
- ☐ Kidney Trouble
- ☐ Circulation Problems
- ☐ Substance Abuse
- ☐ Heart Trouble
- ☐ Hepatitis
- ☐ Gout
- ☐ **OTHER**_____
- ☐ Stomach Ulcers
- ☐ Liver Trouble
- ☐ Leg Cramps
- ☐ RSD/CRPS
- ☐ Asthma
- ☐ Stroke
- ☐ Nerve Disorders/Neuropathy
- ☐ Fractures (broken bones)
- ☐ Bleeding After Surgery
- ☐ Bleeding Disorders
- ☐ Osteoporosis/Weak Bones
- ☐ Cancer
- ☐ MRSA Infection
- ☐ Arthritis
- ☐ Blood Clots
- ☐ Autoimmune Problems
- ☐ Anesthesia Problems
- ☐ **NONE**

Drug Allergies/Previous Surgeries:

_____

Alcohol: YES or NO **Tobacco: YES or NO**

ATTEST

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of any material fact may subject me to al fees for services and/or other liability. I also understand that I am to notify Healthy Feet Podiatry immediately of any changes to the above information and annually upon the office's request.

_____

Patient Name Printed **Patient Signature/Parent/Guardian/POA** **Date**

FINANCIAL POLICIES FOR ADVANCED PODIATRY:

We want you to receive the best care possible and be totally satisfied with our service. Our experienced office staff will be happy to answer any question regarding your account. Here are some important points to remember regarding your care in our office.

1. **To keep medical care and billing costs down, payment for services is due at the time services are rendered unless payment arrangements have been approved in advance IN WRITING by our office manager.**
2. We are contract providers for Medicare and many private insurance plans. In those cases, we have agreed to accept their determination of fees for covered services. These payments are due at the time of service. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.
3. **Not all services are a "covered" benefit in all insurance policies. Your policy is a contract between you and your insurance company, and NOT between Advanced Podiatry and your insurance company.** When we check eligibility and benefits this does not guarantee payment, this only insures that it is an active plan. If your insurance requires prior authorization or referrals for supplies dispensed or services rendered, please understand that it is your responsibility. Your insurance does not release details regarding any pre-existing conditions, exclusions, hidden clauses and non covered services. Medicare and some insurance companies select certain services that they will NOT cover. Payment for these services is the responsibility of you, the patient. We strongly encourage you to carefully read your insurance policy so that you will know the conditions and circumstances of your coverage.
4. Insurance companies may impose a waiting period before providing coverage and they may exclude coverage for what they determine to be "pre-existing conditions." They may also require that you obtain prior approval before treatment.
5. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 70% or 80%) of usual, customary and reasonable (UCR) for this region.
6. When we are able to verify your coverage and benefits in advance for your insurance, we will accept assignment of your insurance benefits and will bill the carrier directly. Accepting assignment means that your insurance company will send us the bulk of the payment for treatment and that you, the patient, pay us directly for the deductibles, co-payments and non-covered services and fees. In these circumstances, payment of your portion will be estimated at the time of services and must be paid at that time. When the insurance company does pay us, or at 45 days from the date of billing your insurance company, whichever occurs first (insurance companies are required by law to pay or deny claims, within 30 days), you will be responsible for any remaining balance or we will refund you any overpayment you have made. Our accepting assignment of your insurance benefits does not relieve you of your personal responsibility for prompt payment of the total bill. If your insurance company does not completely or promptly pay, you are responsible for paying the remaining balance immediately upon receipt of a bill. As a patient of this office, to expedite proper payment, we will complain to the Insurance Commissioner and/or Department of Corporations on your behalf regarding payment of claims.
7. Any account balance not paid in full within 60 days will be subject to a monthly finance charge of 1.5% per month (18% A.P.R) and a monthly cost of rebilling/account maintenance charge of $5.00. These rates and charges are subject to change upon 30 days written notice. If any account balance should remain unpaid for 90 days and the Doctor refers the account to a collection agency or attorney, the responsible party will be charged a 30% collection fee and the costs of collection and these fees and costs will be added to the account balance.
8. Payments will not be delayed or withheld, regardless of any lawsuits, liens, insurance coverage, the pendency of claims thereon or the outcome of medical treatment. All proceeds from the plan are assigned to the Doctor where applicable.
9. Requests for non-customary assistance such as special billing, rebilling, completion of forms and special reports and information requests are not included in our fees and will be billed separately. X-rays and charts are part of you permanent medical records in our office. Copies can be provided upon advance notice and payment of duplicating costs.
10. If your diagnosis or treatment involves others, such as hospitals or laboratories, you will be billed by these entities separately.
11. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.
12. **Check policies**: If a check is returned for insufficient funds **and/or** closed account, you will be charged a $25 return check fee in addition to your balance owed. You will have 7 business days to make good on your check, otherwise, action will be taken.

_____ __/__/____

SIGNATURE: DATE:

Advanced Podiatry

Overview of Insurance & Financial Policy

Advanced Podiatry welcomes you to our practice. We strive to provide you with excellent medical care and make your visit as convenient as possible.

We would like to bring to your attention that health care benefits today have become extremely complicated. Health benefit packages vary greatly based on company and individual selection. For this reason, as well as the ever changing federal healthcare law, our office has found it necessary to adopt the following policies:

- If you have an HMO you must verbally inform our front desk prior to treatment. I understand that Advanced Podiatry does not participate in many HMOs and that I may be responsible for full payment.
- Please realize our office does not know and cannot determine your individual healthcare benefits. We will do our best to maximize coverage for your visit within accepted rules and regulations. However, knowing your benefits and financial liability is ultimately your responsibility.
- Ensuring that our doctors are participating in your health plan is your responsibility. Our office will try to ensure that we accept your health plan prior to your visit, however due to increased plan options, our office can not guarantee that we are participating in your plan. If we are unable to get reimbursement through your plan you will be responsible for all service charges.
- Please inform our office of any insurance, address, email or telephone number changes.
- Our office performs what we feel is medically necessary for your health care based on established medical guidelines and discussions with you.
- Our office will prescribe and recommend those medications which we feel are best for your health. We will do our best to work within any known restrictions. However, please realize any problems concerning the cost or coverage of your medication is between you and your prescription plan. These are financial issues not medical (i.e. prior authorizations).
- Not all services are covered benefits with all insurance plans. Any treatment, including the writing of prescriptions, is not covered under preventative care. Service not covered by your insurance plans are expected to be paid at the time of service.
- You should always be aware of the services being performed and discuss them with the provider.
- You are responsible for applicable charges as per your insurance agreement (such as deductibles, percentage, after hours fees, copays, etc.) or any performed services not covered by your insurance policy.
- If you are turned over to a collections agency or write a bad check, you will be responsible for any costs incurred in collecting the balance.
- Be aware that payment is expected at the time of service and that our office accepts cash, check, Visa, MasterCard and Discover.
- If you have an outstanding balance from a previous visit, you will be asked for payment at your next visit.
- There may be a fee for the completion of paperwork (disability forms, FMLA, prior authorization, etc.)

As your physicians, our relationship is with you and not your insurance company. We realize that problems may arise and we will do our best to work with you through these situations. Please do not hesitate to ask us if you have any questions as we are here to help you.

I have read and understood the above policy and I agree to meet all my obligations.

Patient Name	Patient Signature	Date

Advanced Podiatry

PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby authorize Advanced Podiatry to use and/or disclose to any party deemed reasonably necessary by Advanced Podiatry and its office staff, any and all of my protected health information. I understand that this authorization is valid as long as I am a patient of Advanced Podiatry. I understand that the purpose or use of the disclosure I am granting is to allow Advanced Podiatry's office to use and disclose my protected health information as needed via the communication methods that you have provided (phone, email, address). You have the right to specify the preferred mode of communication. I expressly acknowledge that this authorization is voluntary. There are no other criteria or limitations that I make regarding this authorization. I understand that the office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.

I understand that my health care and payment for my healthcare will not be affected if I do not sign this form. I understand that I may see and copy the information described in this form, if I request it. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.

I acknowledge that I was provided a copy of the Notice of Privacy Practices from Advanced Podiatry and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

I acknowledge that email provided is safe and will only be used by our office and never distributed or shared with other parties. This office has the right to use any email or phone number provided by you to contact you for any and all communications deemed necessary including appointment reminders and other communications from time to time.

PATIENT CONSENT

I hereby voluntarily consent to outpatient care by the podiatrists at Advanced Podiatry, encompassing routine care, diagnostic procedures, examination and medical treatment including, but not limited to, minor surgical procedures, routine laboratory work, x-rays, ultrasound and administration of medications and injections prescribed by Advanced Podiatry. I agree to ask questions to clarify treatment should I not understand the treatment plan.

INSURANCE ASSIGNMENT AND RELEASE

If I have an HMO, I will verbally inform Advanced Podiatry and understand that I may be responsible for full payment as Advanced Podiatry does not participate in many HMO plans.

I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Advanced Podiatry all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

Advanced Podiatry may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits, and if applicable, Medigap benefits, be made either to me or on my behalf to Advanced Podiatry for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare Services. My Medigap insurer and their agents any information needed to determine these benefits for related services.

I understand that any deductibles, coinsurance, denied or non-covered services are my responsibility.

This form has been explained to me and I fully understand this Consent to Treatment and agree to its contents.

This authorization is valid as of ___/___/___, the date I have signed below and will remain in effect as long as I am a patient of Advanced Podiatry. **I have read this complete page and agree to all of its contents.**

Name of Individual/Legal Representative (Print)	Signature of Individual/Legal Representative

Healthy Feet Podiatry

Authorization to Share Protected Health Information

Patient Name

I authorize the physicians and staff of:

Healthy Feet Podiatry

To share protected health information with the following persons:

_____Relationship_____

_____Relationship_____

_____Relationship_____

This includes (please check all areas that apply)

- All Medical Information
- Lab Results
- Medication RX Renewal & Pick Up
- Telephone Consults
- Insurance Information
- Appointment Information
- Other Please Specify

This authorization will be in effect until authorization is revoked.

Patient's signature_____Date_____

ADVANCED PODIATRY, PA
HEALTHY FEET PODIATRY

Leo Krawetz, DPM **Todd Brennan, DPM**
Binh Nguyen, DPM **Jairo B. Cruz, Jr., DPM**
Bret Brennan, DPM **Anh Nguyen, DPM**

North Tampa Office	13801 Bruce B Downs Ste 205 Tampa, FL 33613 (813) 971-4678
Wesley Chapel Office	27658 Cashford Circle Ste 102 Tampa, Fl 33544 (813) 388-9801
South Tampa Office	2919 W Swann Ave. Ste 203 Tampa, FL 33609 (813) 875-0555
Brooksville Office	17222 Hospital Blvd. Ste 218 Brooksville, FL 34601 (352) 796-7800

Date:_____

RELEASE AND ASSIGNMENT

1. For good and valuable consideration, the receipt of which I hereby acknowledge, I irrevocably authorize you and your representatives, licenses and assigns (hereinafter "you") to film, videotape, photograph and/or record me in connection with **Leo Krawetz, Todd Brennan, Jairo Cruz, Binh Nguyen, Bret Brennan, Anh Nguyen and/or Advanced Podiatry, PA dba Healthy Feet Podiatry** and to use such film, videotape, photography and /or recording any number of times in any manner or medium now or hereafter known including without limitation, for example, home video devices, audio records, broadcast television, cable, pay- per- view, Pay TV, theatrical motion pictures, etc… and in advertising and promotion of such uses and for purposes of trade. You shall not be obligated to use any such film, videotape, photography and/or recording.

2. I hereby release and assign to you all rights, worldwide an in perpetuity, relating to such film, videotape, photography, and/or recording and their uses, including but not limited to, the sole and exclusive right to reproduce, distribute, broadcast, sell and otherwise exploit same by any means now or hereinafter known or developed, in whole or part, with the right to edit or modify and to secure copyrights in connection with the aforesaid uses, as your sole property. In addition, you may use my name and likeness in connection with the sale and advertising of the foregoing.

Print Name:_____
Signature:_____
Date of Birth:_____

EMAIL COMMUNICATION OF HEALTH INFORMATION FACT SHEET AND CONSENT FORM

As a patient of Healthy Feet Podiatry, you may request that we communicate with you via encrypted electronic mail (email). This Fact Sheet will inform you of the risks of communicating with your healthcare provider via email. Your health is important to us and we will make every effort to reasonably comply with your request to receive communications via email, however, we reserve the right to deny any request for email communications when it is determined that granting such a request would not be in your best interest.

PLEASE READ THIS INFORMATION CAREFULLY

Healthy Feet Podiatry will make every effort to promptly respond to your requests for information via email, however, ***if you are experiencing an emergency, you should never rely on email communications and should seek immediate medical attention.***

Risks of using email to send protected health information are included, but not limited to:

- **Risk of Unauthorized Access by a 3rd Party:** Do you share a computer with your family? Is your email address or access to email provided through your employer? Do you access your email over an unsecured connection such as public Wi-Fi? Do you access your email on your mobile device? Emails may be accessed by someone you do not wish to know about your health information. Despite necessary precautions, email may be sent to the wrong address by either party. Email may be intercepted or altered in transmission by a computer hacker or computer virus.
- **Unique difficulty in Verifying the Sender:** Email may be easier to forge than handwritten or signed papers. Healthy Feet Podiatry will only send emails to the email address provided, but it may be difficult to confirm that you are in fact the person sending the request for information from your email address.

Procedures

- Emails are not checked outside of normal business hours- this includes overnight, on weekends or holidays.
- Please call Healthy Feet Podiatry at 813-875-0555 to confirm that your request was received if you have not received a response by email or telephone within a few hours.
- If at any time you change your email address or wish to discontinue email communications altogether, you must notify Healthy Feet Podiatry.

PATIENT CONSENT TO UNENCRYPTED EMAIL COMMUNICATIONS

By signing below, you acknowledge your recognition and understanding of the inherent risks of communicating your health information via encrypted email and hereby consent to receive such communications despite those risks. Messages containing clinically relevant information may be incorporated into the medical record at the provider's discretion.

By signing below, you also acknowledge that you have the choice to receive communications via other more secure means such as by telephone or mail. By signing below, you agree to hold Healthy Feet Podiatry harmless for unauthorized use, disclosure, or access of your protected health information sent to the email address you provide.

Client Email Address: _____

Client Signature: _____ Date of Birth: _____

Client Name (printed): _____ Date: _____

If signed by someone other than the Patient, state your relationship to the Patient and a description of your authority to act on the Patient's behalf:

_____