# *Healthy Feet Podiatry*

***WE ARE VERY PLEASED 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** ☐

| | | | | |
|---|---|---|---|---|
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**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 all 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 HEALTHY FEET PODIATRY:**

**We want you to receive the best care possible and be totally satisfies with our service. Our experienced office staff will be happy to answer any questions 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 advanced 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 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 Healthy Feet Podiatry your insurance company.** When we check eligibility and benefits this does not guarantee payment, this only ensures 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 if 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 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 can verify your coverage and benefits in advance for your insurance, we will accept assignment of your insurance, we 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 30days), 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. 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 costs will be added to the account balance.
8. Payments will not be delayed or withheld, regardless of any lawsuit's 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 your permanent medical records in our office. Copies can be provided upon advance notice and payment of supplicating 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**

# *Healthy Feet Podiatry*

## *Overview of Insurance & Financial Policies*

Healthy Feet 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 offices have 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 Healthy Feet 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 cannot 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 discussion 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 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 hour fees, co-pays 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, 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 authorizations, etc.)

As your physician 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 ad I agree to meet all my obligations.

Patient Signature_____ Date_____

# Healthy Feet Podiatry

## PATIENT AUTORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby authorize Healthy Feet Podiatry to use and/or disclose to any party deemed reasonably necessary by Healthy Feet 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 Healthy Feet Podiatry. I understand that the purpose or use of the disclosure I am granting is to allow Healthy Feet 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 filled in before I signed it. I certify that all my questions were answered to my satisfaction and that I understand this authorization form and all its contents.

I acknowledge that I was provided a copy of the Notice of Privacy Practices from Healthy Feet Podiatry and that I have read then 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 voluntary consent to outpatient care by the podiatrist at Healthy Feet Podiatry, encompassing routine foot care, diagnostic procedures, examination, and medical treatment including nit not limited to, minor surgical procedures, routine laboratory work, x-ryas, ultrasound and administration of medications and injections prescribed by Healthy Feet 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 Healthy Feet Podiatry and understand that I may be responsible for full payment as Healthy Feet Podiatry does not participate in many HMO plans.**

I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Healthy Feet Podiatry and all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether paid by my insurance. I authorize the use of my signature on all insurance submissions.

Healthy Feet 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 AUTORIZATION

I request that payment of authorized Medicare benefits, and of applicable, Medigap benefits, be made either to me or on my behalf to Healthy Feet 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, co-insurance, 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 if I am a patient of Healthy Feet Podiatry. I have read this complete page and agree to all of its complete page and agree to all of its contents.

_____ _____

Signature of Individual/Legal Representative (**PRINT**) Name of Individual/Legal Representative

# HEALTHY FEET PODIATRY

**Todd Brennan, DPM, Binh Nguyen, DPM,**
**Bret Brennan, DPM, Anh Nguyen, DPM,**
**Britni Sklencar, DPM  Abir Ghumrawi, DPM**

## 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:**

**Name_____ Relationship_____ Phone_____**

**Name_____ Relationship_____ Phone_____**

**Name_____ Relationship_____ Phone_____**

**This includes (please check all areas that apply)**

**___ All Medical Information**

**___ Lab results**

**___ Medication Rx Renewal and Pickup**

**___ Insurance Information**

**___ Appointment Information**

**___ Other (please specify) _____**

**This authorization will be in effect until authorization is revoked.**

**Patient's Signature _____ Date _____**

# HEALTHY FEET PODIATRY

**Todd Brennan, DPM** **Binh Nguyen, DPM**
**Bret Brennan, DPM** **Anh Nguyen, DPM**
**Britni Sklencar, DPM** **Abir Ghumrawi, DPM**

**North Tampa Office** 13801 Bruce B Downs Ste 205 Tampa, FL 33613 (813) 971-4678

**Wesley Chapel Office** 27658 Cashford Circle Ste 102 Wesley Chapel, 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: _____ Decline_____

**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 **Todd Brennan, Binh Nguyen, Bret Brennan, Anh Nguyen, Britni Sklencar 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: _____

# HEALTHY FEET PODIATRY
# ADVANCED PODIATRY, PA

**Todd Brennan, DPM, Binh Nguyen, DPM,**
**Bret Brennan, DPM, Anh Nguyen, DPM,**
**Britni Sklencar, DPM Abir Ghumrawi, DPM**

| **North Tampa Office** | **South Tampa** | **Brooksville Office** | **Wesley Chapel Office** |
|---|---|---|---|
| 13801 Bruce B Downs | 2919 W Swann Ave | 17222 Hospital Blvd | 27658 Cashford Cir |
| Suite 205 | Suite 203 | Suite 218 | Suite 102 |
| Tampa, FL 33613 | Tampa, FL 33609 | Brooksville, FL 34601 | Wesley Chapel, FL 33544 |
| Phone (813)971-4678 | Phone (813)875-0555 | Phone (352)796-7800 | Phone (813)388-9801 |
| Fax (813)482-0036 | Fax (866)313-3106 | Fax (352)796-1203 | Fax (813)527-9036 |


## 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 Healthy Feet Podiatry, 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 Healthy Feet Podiatry 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 Print name of patient

Date_____