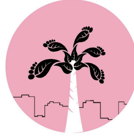


**Kristin Blanchet, D.P.M.**
**Taylor Tendrich, D.P.M.**

Patient Name__________________________________ Date Of Birth___________

FL Address____________________________City__________State___Zip_______

Out of State Address____________________City__________State____Zip_______

Primary Phone#_____________________Secondary Phone#_________________

Last 4 of Social Security Number ____________ Male________Female__________

Email Address____________________________Employer Name______________

Emergency Contact Name______________________Contact #_________________

Family Doctor Name Printed_____________________________________________

Pharmacy Name and Crossroads_________________________________________

Insurance Company Name______________________________________________

**Policy Holder's name___________________________Date of Birth_________**

## How did you hear about our office?________________

Patient Name ______________________________ Date of Birth ____________

What is the reason for you visiting us today?
**(Include foot, ankle and/or Leg.)**
Please be specific. ____________________
________________________________________
________________________________________
________________________________________
________________________________________
When did it start? ____________________

## ***Allergies***

____ **No Know Drug Allergies**
____ Adhesive Tape
____ Aspirin
____ Codeine
____ Demerol
____ Iodine
____ Local Anesthetics
____ Novocaine
____ Penicillin
____ Other ______________

## ***Medical History***

___ Diabetic
___ Neuropathy
___ Stroke
___ High Blood Pressure
___ Low Blood Pressure
___ High Cholesterol
___ Stomach Ulcers
___ Heart Disease
___ Respiratory Disease
___ Blood Clots/DVT
___ Liver Disease
___ Bleeding Disorder
___ Rheumatoid Arthritis
___ Osteoarthritis
___ Kidney Problems
___ Gout
___ Varicose Veins
___ Cancer-Type ______________________
___ Other ____________________________
___ Circulatory Problems
___ **No medical history**

___ Anxiety
___ Depression
___ Anemia
___ Hepatitis
___ AIDS/HIV

Have you seen a Podiatrist before? **Yes** or **No**
If yes, name of Doctor- ____________________
Last Visit ______________________________
Previous Foot Problems: ___________________
________________________________________
________________________________________
Shoe size ________ Width ____________________
Height____________ Weight____________________

## ***Medications***

___ No Medications
Please list or attach a copy of **ALL** medications with Dosage and Strength. ____________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________

## ***Surgical History*** Please list any surgeries that you have had. ____________________
________________________________________
________________________________________
________________________________________

Do you have an advanced directive or living will? Y / N
Have you ever had the Pneumonia Vaccine? Y / N
Have you received a COVID vaccine in the past 12 months? Y / N
**Month Vaccine(s) Given 1st Dose:_____ 2nd Dose_____**
Do you smoke? Y / N
Do you drink alcohol? Y / N
If so, how many per week? ______________

***Name of Primary Care Doctor (or endocrinologist)?**____________________________
________________________________________
***When was the last time you saw this doctor?**_____
________________________________________
***If Diabetic, what was your most recent A1C and when was this done**?
________________________________________
________________________________________

**Treatment:** I give permission for Family First Podiatry to perform general procedures in the diagnosis and/or treatment of my foot condition. I authorize payment of medical benefits to Family First Podiatry for service provided.

**Medical Records Release to Hospitals/Physicians:** I, the undersigned, authorize the release of my medical information to other physicians needed to provide my care. I further authorize release to hospitals and/or healthcare facilities as pertaining to my care. I understand that my records may be faxed to hospitals and/or physicians and that all reasonable efforts will be made to maintain confidentiality.

**Medical Records Release to Family:** I authorize Family First Podiatry to release information pertaining to my illness and/or treatment to_________________________. I authorize Family First Podiatry to leave medical information on my answering machine. I also authorize information to be given to my spouse.

**Medical Records:** One copy of your medical records will be provided upon request at no charge. A pre-paid charge is required for any additional copies. There will be a charge of $1.00 per page. Please allow 10 days for copying all medical records. There is a Xray copy charge of $5.00

**Patient Rights to Confidentiality:** I understand that this office complies with HIPAA regulations. All medical records are confidential and cannot be disclosed without the written consent of the person to whom they pertain. I further understand that under Florida law I have the right to my medical records. I further understand that I may request that my records be released to a physician and/or medical facility: however, this request must be in writing. I understand that by law this office may only release medical records that were generated by Family First Podiatry. We cannot release medical records from other physicians, hospitals or facilities. I agree to accept responsibility for a copying fee as provided by Florida statutes. I understand that employees have no responsibility or liability regarding any aspect of this authorization. Furthermore, I have the right to complain to the practice or the State of HHS if I feel that my privacy rights have been violated. It is the policy of this office that no retaliation of any type will be taken against any patient that files a complaint.

**Payment of Benefits to the Physician/ Provider:** I, the undersigned, understand that Family First Podiatry has agreed to accept Medicare and/or Health Insurance for payment of my medical bills. By my signature below, I acknowledge and understand that I am fully responsible for any yearly deductible and/or coinsurance balance after Medicare or my health insurance payment which is paid to Family First Podiatry. I understand that I am financially responsible for any charges that are not covered by my insurance plan. If I fail to give updated or current information and the claim is denied, I will be totally responsible for the entire balance. I give permission to Family First Podiatry to release any information requested by my insurance company.

**Signature**_______________________________________________**_Date**_ ___________________

## Financial Policy

**Payment is Required at the time service is rendered:** Please present your insurance card(s) to our office staff for photocopying and benefit eligibility verification. You will be responsible for any copay amount at the time of your visit. If you do not have insurance, 100% of the balance will be due at time of service. For your convenience, we accept MasterCard, Visa, American Express and Discover, as well as cash and checks.

In the event your check is returned for any reason, your account will be charged $25.00. In the event it is necessary for your account to be placed with an outside collection agency or attorney, you will be assessed an additional 30% of the balance to recover the collection charges.

**Insurance:** We file your medical insurance as a courtesy. We will warn you if we feel a service may not be covered, however, **it is ultimately your responsibility to understand your insurance benefits as to what services will or will not be covered**. If your claim is not paid within 90 days, the claim will be transferred to patient responsibility. If timely payment is not received, the amount may be referred to a collection agency or attorney.

**Balances Due:** Your Insurance plan is required to send you an Explanation of Benefits (EOB), which will state any balance remaining to be paid by you. At check in, your credit card information will be obtained and kept securely until your insurances have paid their portion and notified us of the balance due, if any. If your Insurance carrier assigns any additional patient responsibility amounts for deductibles, coinsurances, or non covered charges after the claim is processed; we will charge your credit card on file for this payment.

I authorize the office to charge my card on file for any balance due following receipt of any applicable insurance payments in connection with healthcare services rendered by the office. Following each service, the office will submit any relevant insurance claim on my behalf. Upon receiving notice of adjudication of such insurance claim, the office may charge my card on file for the amount of patient responsibility, according to my insurance company. I understand that the office will not be required to provide any further notice to me before charging my card. The maximum amount that the office will charge my card under this authorization is $500. I understand that I will be responsible for any remaining amount due after the office charges my card or if the office cannot charge my card for any reason.

*Please bring the credit card you would like to save on file to your initial appointment*

This will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment.

**Signature________________________________________________Date____________________**

**Authorizations:** I hereby acknowledge that I have read the above policy regarding responsibility to the office for medical services and treatment provided and I agree to pay the office any balances unpaid by my insurance carrier for myself or the below named person.

I hereby authorize the office to charge my credit card or debit card on file for the full amount owed by me for all services and/or treatment rendered by Family First Podiatry in accordance with the terms above.

This authorization shall remain effective unless and until it is revoked by you in writing and delivered to the office.

Thank you for taking the time to review our financial policy. Your cooperation is greatly appreciated. If you have any questions, or require any assistance, we will be pleased to be of service.

I have read this financial policy and understand my rights and responsibilities.

**Printed Name:**____________________________________________________________
**Email address:**____________________________________________________________
**Relationship to Patient: Self___ Spouse___ Parent___ Guardian___ Other________**
**Signature (required):**__________________________________________ **Date:**_________

Per office policy, patients who are unwilling to have a credit card on file with the practice will be required to pay an upfront deposit of $200. This deposit will be in **addition** to the visit copay.

# <u>**Consent for Transfer of Biological Specimen**</u>

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 Family First 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 transfer of any and all biological specimens collected by or deposited with Family First 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 ________________________________________________

Name of Patient Printed ______________________________________________

Date____________________________________________________________