WELCOME TO THE FOOT CARE GROUP, LLC

DATE: _____

FIRST NAME: _____ **MI**: **LAST NAME**: _____

ADDRESS: _____ **CITY**: **STATE**: **ZIPCODE**: _____

DOB: **SSN:** **EMAIL**: _____

HOME PHONE: **MOBILE PHONE**: _____

EMPLOYER: **EMPLOYER PHONE**: _____

PREFERRED NUMBER TO BE REACHED: _____

SEX: **MARITAL STATUS**: _____

MEDICAL DOCTOR: **PHONE:** _____

WERE YOU REFERRED TO US? **IF SO, BY WHOM?** _____

ARE YOU PREGNANT: **ARE YOU TAKING COUMADIN**: _____

HAVE YOU BEEN HOSPITALIZED IN THE PAST FIVE YEARS? _____

IF YES, REASON FOR HOSPITILIZATION: _____

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: CHECK ALL THAT APPLY:

___DIABETES ___HIGH BLOOD PRESSURE ___HEART DISEASE ___ARTHRITIS

___ASTHMA ___CANCER, TYPE_____KIDNEY DISEASE ___ANEMIA

___PACE MAKER ___LIVER DISEASE OTHER: _____

BRIEFLY DESCRIBE REASON FOR VISIT TODAY: _____

WHICH FOOT: LEFT, RIGHT, BOTH: _____

PHARMACY NAME AND ADDRESS: _____

EMERGENCY CONTACT:

RELATIONSHIP: **PHONE:**

FINANCIAL RESPONSIBILITY: (**ONLY** IF PATIENT IS **UNDER** 18 YEARS OLD)

IF SELF CIRCLE: SELF **(IF SOMEONE ELSE IS RESPONSIBLE PLEASE LIST INFORMATION BELOW)**

LAST NAME: FIRST NAME: MI: RELATIONSHIP:

PHONE: ADDRESS: CITY, STATE & ZIP:

SSN:

(IF YOU ARE NOT THE POLICY HOLDER, PLEASE PROVIDE THEIR NAME AND DATE OF BIRTH)

PRIMARY INSURANCE:

POLICY HOLDER:

BIRTH DATE:

IDENTIFICATION#

GROUP/POLICY#

SECONDARY INSURANCE:

POLICY HOLDER:

BIRTH DATE:

IDENTIFICATION#:

GROUP/ POLICY#

PLEASE LIST ALL ALLERGIES:

ALLERGY SEVERITY:

MILD MODERATE SEVERE

MILD MODERATE SEVERE

PLEASE LIST ALL MEDICATIONS AND DOSAGES:

I CERTIFY THAT ALL ABOVE INFORMATION GIVEN IS CORRECT

PATIENT (PARENT/GUARDIAN) SIGNATURE:

DATE

THE FEDERAL GOVERNMENT HAS NOW MANDATED THAT WE ASK THE FOLLOWING QUESTIONS IN ORDER TO UPDATE YOUR PATIENT DEMOGRAPHIC AND MEDICAL PROFILE.

- **PREFERRED LANGUAGE**: _____

- **RACE:** ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other _____ ☐ DECLINE

- **ETHNICITY**: ☐ Hispanic or Latinx ☐ Non-Hispanic ☐ DECLINE

☐ **Decline to provide Language and Race information**

- **GENDER IDENTITY**: _____

- **YOUR SMOKING STATUS:**

☐ Light Cigarette Smoker (1-9 cigs/day)

☐ Moderate Cigarette Smoker (10-19 cigs/day)

☐ Heavy Cigarette Smoker (20-39 cigs/day)

☐ Cigar Smoker

☐ Smoker, current status unknown

☐ Never Smoker

☐ Former Smoker

☐ Unknown if ever smoker

- **HEIGHT**:_____ **CURRENT WEIGHT**:_____ **BLOOD PRESSURE**:_____

- **FAMILY HISTORY**: Do your **immediate family members** have a history of the following: (*Circle yes or no* and **explain relationship to YES answers**)

☐ Diabetes **YES/NO:** _____

☐ Heart Disease **YES/NO:** _____

☐ Cancer **YES/NO:** _____

I CERTIFY THAT ALL ABOVE INFORMATION GIVEN IS CORRECT

PATIENT (PARENT/GUARDIAN) SIGNATURE: _____

DATE

INSURANCE BLANKET ASSIGNMENT:

- I UNDERSTAND THAT **I AM RESPONSIBLE FOR ANY UN-PAID BALANCES DUE TO LACK OF REFERRALS**, INSURANCE DEDUCTIBLES OR ROUTINE FOOT CARE NOT COVERED BY MY INSURANCE.

- I UNDERSTAND THAT, IF MY INSURANCE REQUIRES, IT IS MY RESPONSIBILITY TO PROVIDE A VALID REFERRAL TO THIS OFFICE **BEFORE** SERVICES ARE RENDERED.

- **MEDICARE PATIENTS: I HEREBY ACKNOWLEDGE THAT MEDICARE MAY DEEM CHARGES NOT NECESSARY OR REASONABLE FOR THE TREATMENT OF MY ILLNESS OR INJURY.**

- I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THE CLAIM AND REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY ON ANY UNPAID BILLS FOR SERVICES PERFORMED BE PAID DIRECTLY TO ANY OF THE ABOVE-NAMED DOCTORS FOR SERVICES WHICH THEY ACCEPT ASSIGNMENT.

- I UNDERSTAND THAT IF ANY OUTSTANDING BALANCES SHOULD REQUIRE THE SERVICES OF COLLECTION, INCLUDING REASONABLE COLLECTION AGENCY OF ATTORNEY'S FEE, AND THAT INTEREST WILL BE CHARGED AT THE RATE OF EIGHTEEN PERCENT (18%) PER ANNUM ON ALL BALANCES OUTSTANDING FOR MORE THAN THRITY (30) DAYS.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND HEREBY GIVE PERMISSION FOR MARILYN M. VINOKUR DPM OR JESSICA F. VINOKUR DPM TO TREAT MY FOOT AILMENT.

PATIENT (PARENT/GUARDIAN) SIGNATURE:_____

PATIENT CANCELLATION POLICY

EFFECTIVE OCTOBER 30, 2017 **THERE WILL BE A $50 FEE FOR ANY APPOINTMENTS THAT ARE NOT CANCELLED WITHIN 24 HOURS OF YOUR SCHEDULED APPOINTMENT TIME**.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT.

PATIENT (PARENT/GUARDIAN) SIGNATURE:_____

COPAY POLICY

PER THE AGREEMENT THAT YOU HOLD WITH YOUR INSURANCE COMPANY, YOU ARE RESPONSIBLE FOR ANY COPAYS YOU MAY HAVE WITH YOUR INSURANCE POLICY**. ALL COPAYS ARE DUE AT THE TIME OF THE VISIT PRIOR TO SEEING THE DOCTOR.**

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT.

PATIENT (PARENT/GUARDIAN) SIGNATURE:_____ **DATE**:_____

GUARENTEE OF PAYMENT ON ACCOUNT

I/WE HEREBY GUARENTEE PAYMENT OF ALL CHARGES INCURRED FOR THE ACCOUNT OF THE PATIENT LISTED ABOVE. IF I DO NOT PAY THE ENTIRE BALANCE DUE WITHIN 90 DAYS OF THE MONTH BILLING DATE, OR ARRANGEMENT FOR A PAYMENT PLAN AGREED UPON BY BOTH PARTIES HAS NOT BEEN MADE, I UNDERSTAND THAT MY BALANCE IS SUBJECT TO BE TURNED OVER TO A COLLECTION AGENCY.

I/WE REALIZE THAT FAILURE TO KEEP MY ACCOUNT CURRENT MAY RESULT IN THE DOCTOR NOT BEING ABLE TO PROVIDE ADDITIONAL SERVICES EXCEPT IN AN EMERGENCY OR WHERE THERE HAS BEEN PREPAYMENT FOR SERVICES TO BE RENDERED AT THE VISIT.

IN THE CASE THAT PAYMENT IS MADE BY CHECK, I UNDERSTAND THAT I AM RESPONSIBLE FOR A RETURN CHECK FEE FOR INSUFFICIENT FUNDS OF $40. I UNDERSTAND THAT A CHECK WILL NOT BE ACCEPTED TO COVER THE RETURNED CHECK FEE. FURTHERMORE, I UNDERSTAND THAT AFTER TWO CHECKS RETURNED FOR INSUFFICIENT FUNDS, THIS OFFICE WILL NO LONGER ACCEPT CHECKS AS A FORM OF PAYMENT.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT, I AM AUTHORIZED TO EXECUTE THIS FORM AND ACCEPT AND AGREE TO THE TERMS SPECIFIED.

DATE:_____ **SIGNATURE OF PATIENT** (UNLESS MINOR)_____

SIGNATURE OF RESPONSIBLE PARTY_____

RELATIONSHIP TO PATIENT_____

PRIVACY PRACTICE ACKNOWLEDGMENT FOR THE OFFICES OF THE FOOT CARE GROUP, LLC

DRS. MARILYN AND JESSICA VINOKUR, DPM

I HAVE READ OR RECEIVED THE NOTICE OF PRIVACY PRACTICES AND HAVE BEEN PROVIDED WITH AN OPPORTUNITY TO REVIEW IT.

PRINTED PATIENT NAME:_____ **DOB**:_____

PATIENT (PARENT/GUARDIAN) SIGNATURE:_____ **DATE**:_____

Authorization for Release of Information

I hereby authorize The Foot Care Group, LLC and/or its staff to disclose my individually identifiable health information as described below**. I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY AND OPTIONAL.**

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal law.

This release is good for **1 year** from the date it is signed.

Please list the persons and/or organizations that may receive the information: (ex: Spouse, Primary Care Physician, etc.)

_____

_____

_____

_____

_____

Specific description of information to be used or disclosed:

_____ All Medical Records

_____Specific Dates

_____X-RAYS

PATIENT (PARENT/GUARDIAN) SIGNATURE: _____

Date: _____