FINANCIAL POLICY

We Accept Visa and MasterCard

Welcome To Our Office

Thank you for choosing us as your podiatric physician. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. As part of our service, we try to contain the cost of health care. In an effort to do this, we have implemented a Financial Policy.

The following is a statement of our **FINANCIAL POLICY** which we request you read and sign prior to any treatment. To avoid any misunderstandings, please contact us should you have any questions about our policies.

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment.

PAYMENT: Payments for the balance due are due at the time of service and may be made by *cash, check or credit card* (Visa, MasterCard, Discover). There will be a $25.00 charge for *returned checks. Delinquent accounts* will be referred for collection at the discretion of the office manager.

MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment. Young adults (age 18 & over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement, regardless of insurance coverage.

MISSED APPOINTMENTS: Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. We reserve the right to charge for missed appointments.

ORTHOTICS: Orthotics are a non-covered service by some insurance plans. Please check with your insurance company *prior* to the examination and casting for orthotics to determine your orthotic benefits. A deposit of $150.00 is requested at the time of the examination and casting and full payment is due when the orthotics are dispensed.

I have read and agree to the terms set forth in the above financial policy. I am financially responsible for any balance due.

SIGNED_____ **DATE**_____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

We keep a record of the health care services we provide you. You may ask to see and copy that record. If you would like to obtain a copy of your medical records, a base clerical fee of $20.00 is due upon receipt. Our office has up to 30 days to respond to the request.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

This form will be retained in your medical record.

KAISER PATIENT REGISTRATION

Patient Information

Patient Name: Last	First	M.I.	□ M □ F

By what name to you preferred to be addressed?	Cell phone:

Address:

City	State	Zip

Email (Important!!please write this down so we can get in touch with you because no one answers their phone anymore)

Age:	Birthdate (for patient ID reasons)

Referral

☐ Dr. Domenigoni ☐ Dr. Heck	☐ Dr. Peng	☐ Dr. Krahnke	☐ Dr. Neary
☐ Dr. Laxson ☐	☐ Dr. Arndt	☐ Dr. Evans	☐ Other

Medical History - Confidential Information

Symptoms

Which Side: ☐Right ☐Left ☐Both

Type of Pain: ☐Dull ☐Achy ☐Throbbing ☐Burning ☐Sharp ☐Shooting

Area of Pain:_____

Onset: ☐ Slow ☐ Sudden ☐ Traumatic

Duration:_____

Has pain gotten: ☐Better ☐Worse ☐Stayed the Same

What aggravates condition? ☐ walking ☐ running ☐ standing ☐shoes

What have you tried to help the pain? ☐ Changing shoes ☐anti-inflammatories ☐ decrease activities

Other:_____

How long does pain last?_____

Have you ever had a similar pain? (describe, including treatments received)

_____

Runners Only

How long have you been running?

_____

Mileage: _____ miles per ☐ wk ☐ month

General

What is your weight: _____

What is your height: _____

What is your shoe size: _____

Allergies and Drug Intolerance

☐ Adhesive/Tape	☐ Aspirin
☐ Codeine	☐ Iodine
☐ Local Anesthetics	☐ Penicillin
☐ Seafoods	☐ Sulfa
☐ No known drug allergies	☐ _____
	☐ _____

Lower Extremity Surgeries and Injuries

List lower extremity surgeries and injuries, not previously listed:

_____Date:_____

_____Date:_____

_____Date:_____