

Today's Date: ___/___/___

Updated Info: ___/___/___

Patient Information

Name: _____

Phone #: _____ - _____ - _____

Cell #: _____ - _____ - _____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Birth date: ___/___/___ Age: _____

SSN: _____ - _____ - _____ Male/Female

Height: _____ Weight: _____ lbs /Shoe Size: _____

Occupation: _____

Are you Diabetic? Yes or No

Are you in a Skilled Nurse Facility? Yes or No

Do you have Home Health Care? Yes or No

Are you receiving Hospice? Yes or No

Have you seen a podiatrist before? Yes or No

Who? _____

Is this a work-related injury? Yes or No

In case of emergency contact? _____

Do you want to put someone on your HIPAA?

Yes or No Who? _____

**** IMPORTANT Information ****

Primary Care Physician: _____

PCP Phone #: _____

PCP Fax #: _____

Pharmacy Name: _____

Pharmacy Phone #: _____

Insurance Information

Primary Insurance: _____

Policy #: _____

Policy Holder: _____

Relationship: _____

DOB: ___/___/___

SS#: _____ - _____ - _____

ANY OTHER INSURANCE? Yes or No

Secondary Insurance: _____

Contract #: _____

Primary Insurance: _____

Policy #: _____

Insurance Assignment & Release

I request that payment of authorized benefits will be made on my behalf to Karr Foot Kare, PA for any services rendered to me. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on claim form, my signature authorizes releasing of the information to the insurer shown. The physicians or suppliers agree to accept the charge determination of the insurance carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, copay and/or non-covered on unpaid services. Coinsurance, copay, and the deductible are based upon the charge determination of the carrier.

X _____
Signature of Patient/Representative Date

Patient Visit

Why are you here? _____

Who were you referred by? _____

How did you hear about us? Google, Yahoo, Online, Patient, _____

Do you want to share your info with anyone and whom? (Place on form)

Continued on Next Page; Patient Initials _____

Patient Name: _____

Medications

List medications you are currently taking OR attach a medication list.

Name of Medication	Dose

Drug Allergies

1. _____
2. _____
3. _____
4. _____
5. _____

Past Surgeries

List all past surgeries (entire body):

1. _____
2. _____
3. _____
4. _____
5. _____

Family History

Has anyone in your family had?

Type	Father	Mother	Sibling
Rheumatoid Arthritis			
Diabetes			
Heart Problems			
Lupus			
Stroke			

Risk Factors

Type	Present Use/Amount	Past Use/Amount
Tobacco		
Alcohol		
Other		

Review of Systems

Cardiovascular	Yes	No	Past
Stroke			
Chest Pain			
Hypertension			
Phlebitis/Clots			
Oxygen at home			
Pacemaker			
Swelling			
Varicose veins			
Rheumatic Fever			
Respiratory	Yes	No	Past
Frequent Colds			
Difficulty Breathing			
Cough			
Asthma			
Emphysema			
TB			
Gastrointestinal	Yes	No	Past
Black Stools			
Blood in Stools			
Peptic Ulcer			
Abdominal Pain			

Continued on Next Page; Patient Initials _____

Patient Name: _____

Genitourinary	Yes	No	Past
Renal Disease			
Dialysis			
Frequent/Burn on urination			
Blood in urine			
Difficulty in urination			
Incontinence			
Menses/Vaginal Bleeding/Pain			
Testicular/Prostate Problems/Pain			
Musculoskeletal	Yes	No	Past
Leg Pain			
Back Pain			
Joint Pain			
Deformities			
Integumentary	Yes	No	Past
Rash			
Masses/Lumps			
Birthmark/Warts			
Lumps/ Nodules			
Slow to heal			
Bleeding/bruise			
Hair Growth			
Skin Cancer			
Neurological	Yes	No	Past
Spinal cord injury			
Seizures			
Tremors			
Numbness/Tingling			
Changes in sensation			
Difficulty with Balance			
Psychiatric	Yes	No	Past
Depression/Anxiety			
Memory Change			
Insomnia			

Endocrine	Yes	No	Past
Diabetes			
Thyroid Disease			
Excessive Thirst			
Heat/Cold Intolerance			
Hematologic/Lymphatic	Yes (Mo/Yr)	No	Past
Anemia			
Blood abnormalities			
Allergic/Immunologic	Yes (Mo/Yr)	No	Past
Rheumatoid Arthritis			
Lupus			
Sickle cell Anemia			
Sclerodema			
Vasculitis			
Other	Yes (Mo/Yr)	No	Past
Chemotherapy			
Radiation			
Evidence of Abuse/Neglect			

Continued on Next Page; Patient Initials _____

Karr Foot Kare, PA

POLICIES AND PROCEDURES

Thank you for choosing Karr Foot Kare, PA as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

- 1. Insurance.** We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but your services are denied, payment is required in full. Knowing your ins benefits is your responsibility. Please contact your ins company with any questions you may have regarding your coverage.
- 2. Medicare.** Those with who do not have a secondary insurance will be responsible for their 20% at the time of service, unless other arrangements have been made. If you have a secondary insurance that we are not contracted with, you will also be responsible for your 20% coinsurance.
- 3. Co-payments and deductibles.** We do require you to pay your co-payment, co-insurance or deductibles at the time of service. If you are unaware of what your benefits are, you should contact your benefits department prior to your appointment. It is your responsibility to understand the terms and benefits of your contract.
- 4. Non-covered services.** Please be aware that some of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit or if deemed non-covered after services submitted to your insurance, you will be responsible and billed for the services.
- 5. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become nonrefundable if the proper referral is not obtained by then.
- 6. Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. For secondary payers', we will submit the claim one time as a courtesy to you if they do not pay within 35 days of submission, it will then become your responsibility.
- 7. Coverage charges.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
- 8. Nonpayment.** Invoices are sent out every 30 days. Your prompt payment will assist in keeping the cost of healthcare down. If your account is over 60 days past due, we will be forced to send your account to an outside agency. We try our best to avoid this as there are additional fees, and your credit can be affected. Please call our office if you have an outstanding balance to arrange a payment plan.

Continued on Next Page; Patient Initials _____

9. A \$10.00 rebilling fee will be charged for each additional invoice sent out after 30 days. Partial payments will not be accepted unless otherwise approved by our Billing Department. Please be aware that if a balance remains unpaid, we may refer your account to small claims court and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

- 10. Referral/Authorization.** In the event your insurance requires a referral or authorization from primary physician, it is *YOUR* responsibility to make arrangements with that office to get the referral/authorization to us prior to your appointment. *Your appointment will be rescheduled if the appropriate referral/authorization is not received.*

- 11. Missed appointments.** Our policy is to charge \$10.00 for missed appointments not canceled within twenty-four hours (business days) of your appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment. After 3 consecutive missed appointments, payment must be made before rescheduling. Missed procedures \$25 fee. Canceled surgery \$50 fee.

- 12. Medical Records.** All medical record requests must be submitted in writing. After the patient signs an authorization of release, we will provide any doctor's office with a copy of your medical records free of cost. If you or your legal representative will need copies of medical records, we will provide them for the cost of \$1.00 per page for the first 25 pages then \$.25 per page thereafter. Prepayment is required. Patient statements can be issued once a year free of charge. Otherwise, the customary \$1/page applies.

- 13. Forms and Documents.** A fee of \$25.00 per form is required for the completion of forms, including but not limited to disability forms & FMLA. Please allow 3-5 business day's turnaround time for form completion. If any medical records will be needed with disability form or FMLA, to be attached or sent, it will be an additional cost of \$.50 per page. Prepayment is required.

- 14. Fees.** Our fees are representative of the usual and customary charges for our area.

- 15. Refunds.** Should you make an overpayment, you will be refunded thirty days after your treatment cycle is complete.

I have read and understand the above policies and procedures and will adhere to them.

Also, I authorize the release of any medical information necessary to my insurance company, hospitals or physicians involved in my care. I also authorize payment of medical benefits to Karr Foot Kare, PA, Jeffrey C. Karr, and any/all doctors of Karr Foot Kare, PA.

 Printed Name of patient or responsible party

 Signature of patient or responsible party

 Date

Patient Name: _____

Consent for Treatment

1. **Authorization for Treatment:** I authorize Dr Jeffrey C Karr and Karr Foot Kare, PA to provide and perform medical care, tests, procedures, medications, and other services deemed advisable or necessary for me, (or for my minor if applicable), for diagnosis, medication, and treatment. This is valid until I rescind authorization in writing.

This is written consent necessary to comply with Florida's 'parental consent' law.

2. **Authorization for Communication:** I authorize Dr Jeffrey C Karr and Karr Foot Kare, PA to communicate with myself concerning my treatment or that of my minor.

Authorization of Payment

3. **Release of Information from Karr Foot Kare:** I authorize Dr Jeffrey C Karr and Karr Foot Kare, PA to release my medical records concerning my treatment, hospitalization, and/or outpatient treatments to my insurance company(s) and any of its' affiliates as well as my physicians. This includes alcohol abuse, drug abuse, and/or Acquired Immune Deficiency Syndrome.
4. **Copayments, Co-insurances, and Deductibles:** I understand payment is required at time of service. I agree to pay the deductible and co-insurance when services are rendered.
5. **Pre-Certification, and/or Authorization Requirements:** If my insurance company requires pre-certification, I understand that it is my responsibility to contact them to obtain the certification. Should I fail to do so, I accept full responsibility for payment.
6. **Primary Insurance:** I understand that should my primary insurance company set limits upon care and treatment performed by a Podiatrist, that I am responsible for the any amounts

exceeding the limits and that I am responsible for any co-payments. I also understand that Karr Foot Kare, PA has done due diligence to verify benefits, however should my insurance company deny payment, I am responsible for payment.

7. **Secondary Insurance:** For any secondary insurance listed, I request payment of authorized benefits be paid to Karr Foot Kare, PA. Should I fail to provide this information or should payment be denied, I understand that I am responsible for full payment.
8. **Testing and Other Fees:** I understand that if any tests are done or requested by Dr Jeffrey C Karr they are billed separately by the testing agency and are not part of the payment for the doctor visit. I also understand the amount charged to me at time of service is the required fee for service and that no refunds will be issued. I further agree to pay all cost of collection if I fail to pay any sums due within 3 months of services rendered.
9. **Cancellation/No Show Policy:** I understand the practice policy. Should I cancel with less than I business day or not show up, I agree to pay the \$10 admin fee. I also understand the practice does not always make reminder calls.

Signature of Patient:

X _____

Date: / / _____

OR

Signature of Legal Representative of Patient:

X _____

Relationship to Patient: _____

Date: / / _____

Continued on Next Page; Patient Initials _____

Karr Foot Kare, PA

Acknowledgment of Notice of Privacy Practices, Policies and Procedures and Permission Form

Patient Name: _____ **Date of Birth:** _____

I, _____, hereby acknowledge that I have reviewed and received a copy of the office's Notice of Privacy Practices explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligation concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to any revised *Notice of Privacy Practices* upon request.

I also understand that I have any questions or complaints, I may contact:

The Office Manager
Kim Karr
5421 S. Florida Ave
Lakeland, FL 33813
(863) 646-5960

You may also contact the Secretary of US Department of Health and Human Services and any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the US Department of Health and Human Services.

PATIENT OR PERSONAL REPRESENTATIVE

X Signature: _____

Date: ____/____/____

Name: _____

Relationship to Patient: _____

FOR OFFICE USE ONLY

We made a good-faith effort to obtain an acknowledgement of this patient's receipt of our *Notice of Privacy Practices*. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

Patient refused to sign (date of refusal) ____/____/____

Communications barriers prohibited obtaining an acknowledgment.

An emergency situation prevented us from obtaining an acknowledgment.

Attempt was made by: _____

Karr Foot Kare, PA

**Patient Consent & Authorization for Release of Protected Health Information
Permission Form (for HIPAA compliance)**

Patient name: _____

Patient DOB: _____

Hereby authorize Dr. Jeffrey C Karr and Karr Foot Kare, PA to disclose my health information. I give permission for Dr Karr or his office staff to speak, fax, or electronically communicate with:

Name: _____

Relationship: _____

Phone #: _____

on my behalf concerning my account and/or treatment/mediation/care in accordance with Health Insurance Portability and Accountability Act of 1996. Unless otherwise stated, this authorization will stand in place until revoked or ten years from signed date, whichever occurs first.

Printed Name of patient or responsible party

Date

X _____
Signature of patient or responsible party

Witness Signature: _____