Patient Information

(Confidential Information - Important for Our Files and Your Health)

Patient: _____ Date of Birth: _____
Last Name First Name MI

Home Address: _____ City: _____

State: _____ Zip Code: _____ Apt. # _____ Home Ph #: _____

Social Security Number: _____ Day Ph #: _____

Spouse Name: _____ Phone: _____

E-Mail Address: _____

Responsible Party if Patient a Minor: _____

Primary Insurance Company:

Policy Number: _____ Group #: _____

Claims Address: _____

Phone Number: _____ Co-pay: _____

Policy Holder: _____

Secondary Insurance: _____ ID # _____

Claims Address: _____ Ph # _____

Policy Holder: _____

Whom may we thank for referring you to this office? _____

Medical History

Family Physician: _____

Has he/she requested you to be seen in our office? Yes: No:

Former Podiatrist: _____

What problems bring you to our office?

_____

List All Medications	Dosages	Medications	Dosages
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please check “Yes” or “No” to indicate whether you have had any of the following problems.

Nature of problem	Yes	No	Approximate Date	Comments
Recent weight loss				
Headaches				
Trouble with vision				
Trouble with hearing				
Allergies/Hay Fever				
Asthma				
Allergic reaction to Medication/Latex				
Thyroid				
Diabetes				
Skin Problems				
Anemia				
Heart				
Mitral Valve Prolapse/Heart Murmur				
Circulation				
High Blood Pressure				
Chest Pain				
Lungs (COPD, Pneumonia, TB, etc.)				
Shortness of Breath				
Cough, pleurisy, wheezing				
Liver or Gall Bladder Disease or Jaundice				
Stomach Trouble				
Swelling in Feet or Ankles				
Arthritis				
Kidney Disease or Stones				
Gout				
Bleeding Tendency				
Scarring Tendency				
Joint Pain or Stiffness				
Numbness in Feet or Legs				
Cramps in Feet or Legs				
Lower Back Pain				
Do you Smoke			How Much	
Do you drink			How Much	
Do you take any drugs			How Much	
Fainting & Convulsions				
Stroke				
HIV Positive				
Psychiatric				
Pain in other areas				
Other illnesses or problems				

Please indicate if any of your immediate relatives have had any of the following:

Nature of problem	Yes	No	Who	Comments
Cancer				
Heart Trouble				
Kidney Disease				
Stroke				
Diabetes				
High Blood Pressure/Hypertension				
Mental/Emotional Problems				
Arthritis				

Please give details of any:

Operations/Procedures	Hospital	Date	Physician

Have you previously had physical therapy? Yes: _____ No: _____

When: _____ Where: _____ For what: _____

For Women Only Are you pregnant? Yes: _____ No: _____ How many months: _____

Name of pharmacy most frequently used:_____
Pharmacy phone number:_____ Fax number:_____

Patients Signature: Witness:

Date: Date:

RELEASE & ASSIGNMENT OF BENEFITS

- I hereby authorize payment of medical and surgical benefits directly to Fred O. Kussel, D.P.M., and to release any information, including the diagnosis and treatment rendered to me.
- I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers any information needed for this or related Medicare claim.
- I request that payment of authorized benefits payable for physician services be paid directly to Fred O. Kussel, D.P.M. for services rendered to me. I also understand that Dr. Kussel will accept assignment of all Medicare covered services provided that I pay the 20% of the approved amount and have met my deductible.
- I understand that I am ultimately responsible for any charges regardless of my insurance. Dr. Fred Kussel's office will make all reasonable attempts to obtain payment from my insurance company. However, if these attempts fail, I realize that I am responsible for the charges, including the 20% co-pay for Medicare or any HMO or PPO co-pays. These fees are due when services are rendered.
- I understand that original x-rays are property of the practice and I can request copies for a fee and must allow adequate time to obtain these copies.
- I understand that I am responsible for the payment of Custom Fitted Orthotics and that this payment is non-refundable due to the nature of the device being made specifically to my feet.

Signature_____ Date _____

PRIVACY HEALTH INFORMATION- PRACTICE'S REQUIREMENTS

The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided under federal law.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This notice is in effect as of 04/15/2003.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient:_____

Date:_____

Due to HIIPA guidelines, we can not give out any medical information unless we have your written consent to do so. It is important for us to know who you would like us to give information to in case we receive a call. If you are a single parent it is most important to know if we can speak to the other parent of the minor child.

Please give us a list of the persons we may speak to regarding your account. If this information changes it is important for you to call our office immediately to update this list.

1.) _____

2.) _____

3.) _____

4.) _____

5.) _____

6.) _____

7.) _____

8.) _____

9.) _____

10.) _____

Please give us a specific list of names that you DO NOT want any information released to:

1.) _____

2.) _____

3.) _____

4.) _____

5.) _____

Please list specific medical conditions that you do not want us to discuss with anyone.

1.) _____

2.) _____

3.) _____

4.) _____

5.) _____

_____ _____

Signature Date

CHART UPDATE

Please answer all of the following questions so that we may update your chart. This information required for the current Government regulations for tracking purposes only.

Circle the appropriate choice

1.) Gender:
   a. Unknown
   b. Male
   c. Female
   d. Other
2.) Race:
   a. Unknown
   b. American Indian/Alaska Native
   c. Asian
   d. Black/ African American
   e. Native Hawaiian/ Pacific Islander
   f. White
3.) Ethnicity:
   a. Unknown
   b. Hispanic or Latino
   c. Non Hispanic or Latino
4.) Language:
   a. Unknown
   b. English
   c. Spanish
   d. French
   e. Russian
   f. Italian
   g. Dutch
5.) Smoking Status:
   a. Current, every day
   b. Current, some days
   c. Former
   d. Never
   e. Former, current unknown
   f. Unknown
6.) E mail address:

7.) Pharmacy Name:

8.) Pharmacy Location:

9.) Pharmacy phone number:

Patient Signature_____

Lisha/newpatientdocuments

Dr. Fred Kussel DPM
2378 Sunset Point Rd
Clearwater, FL 33765
727-797-5007

Office Policy On Billing

The following bullet points are very important for you to read and understand regarding our billing policy.

- Before your initial appointment this office will check your insurance coverage and what responsibility you will have. It is important for you to understand that when we do this the insurance company makes it very clear to us that what they tell us is not a guarantee of payment and that it is subject to change when the claim is processed. Therefore, when we inform you of your benefits they are not written in stone and are subject to change at your insurance companies discretion. It would also be advisable for you to also call your insurance company and verify your coverage as well as to whether or not Dr. Kussel is participating with your particular insurance.
- This office will charge an additional fee for any Medical Records and copies of X-Rays that you may request. There will be no exceptions. A 48 hour notice is required.
- Please understand that your insurance is a contract between you and them. We have no control as to what they put to your responsibility. However, due to our contract with the insurance companies we are not at liberty to adjust off balances for co-pays, deductibles and co- insurance rates.
- This office collects all financial obligations that we are aware of on your account before you are seen by the doctor.
- If for some reason the insurance does put an obligation to you that we were not aware of, we will mail out a bill to you. It is very important that you make payment on that billing within 30 days. Effective January 1, 2009 we have implemented a service fee of $1.00 for every bill we have to mail after that.
- Please provide your insurance cards and a photo ID at your initial appointment that we can copy for your chart. It is your responsibility to inform us if your insurance changes. It is not the responsibility of this office to check your insurance for every appointment.

_____ _____

Patient Signature Date