Welcome to our Podiatry Office. Please fill out the entire packet and sign where designated under the Financial Agreement, Insurance Assignment, and Consent. For patients who are here solely for a free consultation, please complete the first page only.

1 Patient Identification

NAME:____
First MI: Last

ADDRESS:____
Street Town State ZIP

___ ___ ___ - ___ ___ - ___ ___ ___ ___ [ ] M [ ] F ______ ______________________
Social Security Number: **Sex** **Age** **Birth Date**

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

Occupation: ______________________ **Employer**: ______________________

Email: ____

2 Contact Information

Phone Numbers For Contacting You:

Day: (_______) - ________ - ___________

Evening: (_______) - ________ - ___________

Cell: (_______) - ________ - ___________

Best Time To Call: [ ] Morning [ ] Afternoon [ ] Evening [ ] Weekend

Emergency Contact:

Name: ______________________

Relationship: ______________________

Day: (_______) - ________ - ___________

Evening: (_______) - ________ - ___________

Primary Doctor (PCP) Information:

Name:______________________

Address:______________________

____

Phone:______________________

Preferred Pharmacy Information:

Name:______________________

Address:______________________

____

Phone:______________________

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3 Insurance Information

Name of Insured :____ ________________________________
Relationship to Patient: [ ] Self, [ ] Spouse, [ ] Parent, [ ] Legal Guardian, [ ] Common-Law Partner
Insurance Co. ____
Policy # ________________________________Group #____
Specialist Co-Pay: $__________ Do you have a HSA or In-Network Deductible: [ ] YES [ ] NO
Is patient covered by additional insurance [ ] YES [ ] NO
Subscriber Name: _________________________ ____
Relationship to Patient: [ ] Self, [ ] Spouse, [ ] Parent, [ ] Legal Guardian, [ ] Common-Law Partner
Birthdate: ___________________ SS # ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Insurance Co. ____
Policy # ________________________________Group #____

4 Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above listed insurance and assign directly to Dr. Kolberg all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____

Responsible Party Signature

_____________________________________ ____________________

Relationship **Date**

5 Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Kolberg for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. 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 other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.

____ ____________________

Beneficiary Signature **Date**

Office Use Only: Chart Number: ___ ___ ___ ___ ___ ___ ___ ___ Origination Date: _______________________ Pt referred by:___________________________

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6 Financial Agreement

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO COPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **APPOINTMENTS**: Please provide 24 hours' notice in the event you need to cancel or reschedule your appointment. Abuse of this policy may result in a cancellation fee of $25 to be added to your account.

- **REFERRALS**: If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain this prior to your appointment and have it with you at the time of your visit. If you do not have the referral, YOU WILL BE ASKED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with a valid referral within 48 hours or you will be personally responsible for that day's services.

- **CO-PAYMENTS**: By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service and we subsequently have to send you a statement, an administration fee of $20 may be added to your account.

- **OUT OF NETWORK PLANS**: You will be responsible for any balance your plan indicated as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's usual, customary, and reasonable charges. All patients will be responsible for their co-insurance and deductible. If we do not participate with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days; you will be responsible for the full amount. Should you receive payment from your insurance carrier, please forward it to the physician's office.

- **SELF-PAY PATIENTS**: Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

- **MEDICARE**: We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which will be billed to a secondary insurance if you have one.

  Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Dr. John Kolberg, DPM, for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administrating claims of benefits.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, OR AMEX.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us any special concerns.

Patient Name:____DOB:____________________

Responsible Party Signature:______________________________Date:____________________

Print Name:____Relationship:______________

Office Use Only: Chart Number: ___ ___ ___ ___ ___ ___ ___ ___ Origination Date: ______________________ Pt referred by:__________________________

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7 Patient's Current Chief Complaint

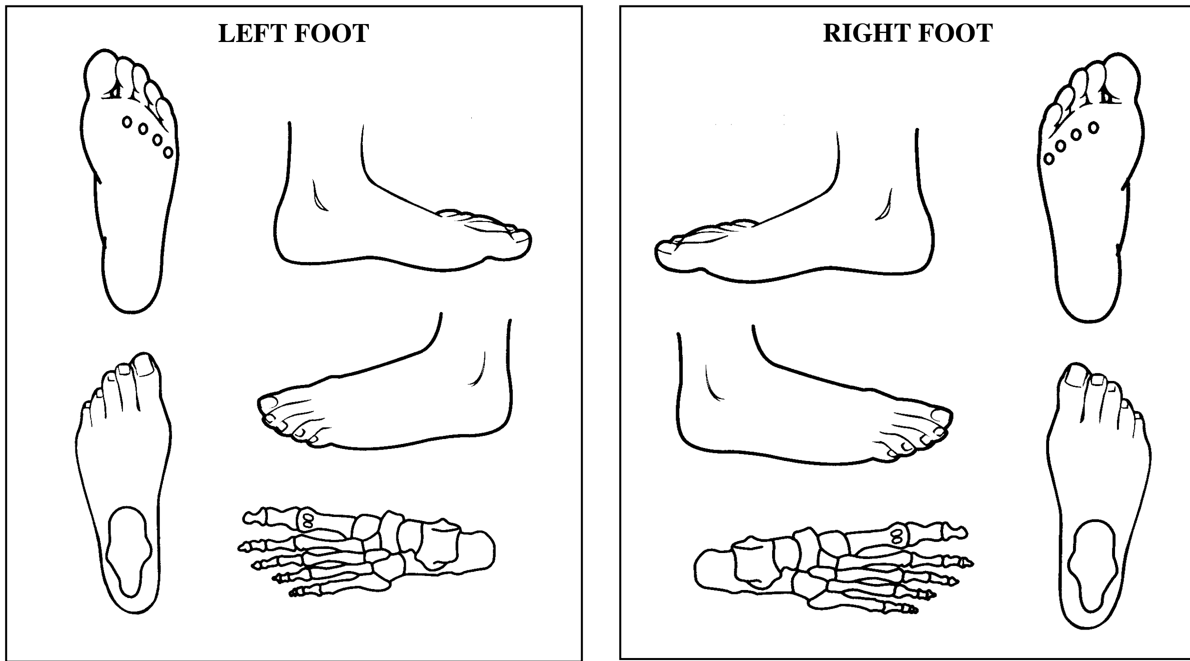
What is your chief complaint for which you came to be treated? (Include foot, ankle, thigh, and hip complaints.)

____

____

____

Draw on Diagram where you are having the complaint(s):



Is this injury related to an accident at work? [ ] Yes [ ] No

Date of Injury: ________________________ Date of Report to Employer:______________________________

Have you ever been to a Podiatrist before? [ ] Yes [ ] No

If yes, please list. Dr. ___________________________________ Last visit: ________________________________

PAIN: Please indicate the severity of your discomfort: [ ] None [ ] Mild [ ] Moderate [ ] Strong [ ] Severe

PAIN: Described as: [ ] Shooting [ ] Throbbing [ ] Sharp [ ] Burning [ ] Itching [ ] Aching [ ] Tender [ ] Dull [ ] Tingling [ ] Numbness

How Long Have You Had This Complaint: ___ Days ___Weeks ___ Months ___ Years

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8 Comprehensive Patient Medical History

Please check to indicate if you have had any of the following:

AIDS/HIV	[ ]	Hepatitis or Jaundice	[ ]
Anemia	[ ]	High Blood Pressure	[ ]
Angina	[ ]	Kidney Problems	[ ]
Arthritis	[ ]	Liver Disease	[ ]
Artificial Heart Valves or Joints	[ ]	Low Blood Pressure	[ ]
Asthma	[ ]	Nerve Disorders	[ ]
Back Problems	[ ]	Phlebitis	[ ]
Bleeding Disorders	[ ]	Psychiatric Care	[ ]
Cancer	[ ]	Radiation Treatment	[ ]
Chemical Dependency	[ ]	Rash	[ ]
Chest Pain	[ ]	Respiratory Disease	[ ]
Chronic Diarrhea	[ ]	Rheumatic Fever	[ ]
Circulatory Problems	[ ]	Shortness of Breath	[ ]
Diabetes	[ ]	Sinus Problems	[ ]
Ear Problems	[ ]	Special Diet	[ ]
Epilepsy	[ ]	Stroke	[ ]
Eye Problems	[ ]	Swelling in Ankles, Feet	[ ]
Fainting	[ ]	Swollen Neck Glands	[ ]
Foot or Leg Cramps	[ ]	Tired Feet	[ ]
Gout	[ ]	Tuberculosis	[ ]
Headaches	[ ]	Ulcers	[ ]
Heart Disease	[ ]	Varicose Veins	[ ]
Hemophilia	[ ]	Venereal Disease	[ ]
Lung Disease	[ ]	Weight Loss, unexplained	[ ]
Thyroid Disorders	[ ]	Stomach Ulcers	[ ]
Hypercholesterolemia	[ ]	Osteoporosis	[ ]
Alzheimer's	[ ]	Gastro-intestinal Disorders	[ ]
Dementia	[ ]	Other:________________________	[ ]
Other:______________________	[ ]	Other:________________________	[ ]

Is there any personal or family history of diabetes? [ ] Yes [ ] No

Cigarette / Tobacco use _________________

Years Smoked ________________________

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Athletic activities in which you participate (please list and indicate frequency)

____

____

Please list any surgeries you have had:

____

____

____

Hospitalization other than for the surgeries listed:

____

____

____

9 Medications and Allergies

Medications: Include prescriptions, OTC medications and vitamins:

____

____

____

____

____

____

____

____

Allergies

[ ] Adhesive/Tape
[ ] Anticoagulant Therapy
[ ] Aspirin
[ ] Codeine
[ ] Demerol
[ ] Iodine
[ ] Local Anesthetics
[ ] Novocaine
[ ] Penicillin
[ ] Seafood
[ ] Sulfa
[ ] Other_________________

10 Consent

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature ____**Date**_______________

Office Use Only: Chart Number: ___ ___ ___ ___ ___ ___ ___ ___ Origination Date: ________________________ Pt referred by:____________________________