Dr. Kostadinka H. Skandeva, DPM DATE OF APPOINTMENT OR UPDATE _____

PATIENT INFORMATION (please print, fill out all sections completely – <u>all sections are required</u>)

LEGAL NAME (First) _____ **(Last)** _____ **(M.I.)** _____

___Female ___ Male ____ Married ___ Single ___ Divorced ___ Widowed ___ Child (under 18)

NICKNAME_____ **BIRTHDATE**____/____/_____ **SS#**_____/____/_____

PHONE: (____) _____-_____ (Home) **(**____) _____-_____ (Cell) **(**____) _____-_____ (Work)

I authorize NOVA Foot & Ankle Center to contact me at the above mentioned phone numbers _____ (Initial)

Please indicate how you would like to receive appointment confirmations: __Call __Text __Email ___All listed

MAILING ADDRESS_____**CITY**_____**STATE**___ **ZIP**_____

EMAIL ADDRESS_____

EMPLOYER (School, if student) _____ **___ Retired**

FAMILY DR. (Name and Phone Number): _____

Pharmacy Name _____ **Phone (**_____) _____-_____

Pharmacy Address _____

MEDICARE PATIENTS: *EXACT* DATE OF LAST VISIT: _____

FAMILY CONTACT INFORMATION: ___ Spouse ___ Parent/Guardian ___ Other (Relationship: _____)

Name _____**Address** _____**City** _____ **State/ZIP**___

Phone (_____) _____-_____

Their Employer _____ Phone (_____) _____-_____

Name & Phone # of closest person not living with you to contact in case of emergency:

Name: _____ **Phone: (**____) _____-_____

****

<u>Payment Information</u>

***Please <u>COMPLETE ALL</u> information below <u>and</u> hand your insurance card to the receptionist. Our billing company requires both to properly submit your claim for payment.**

<u>Primary Insurance Company</u> _____ **Group #** _____
Name of policyholder _____ **ID #** _____
Employer _____**Policyholder's SS #** _____ **Policyholder's Birth date**_____
Relationship to policyholder: _ Self _ Spouse _ Child _ other (please specify :_____)

<u>Secondary Insurance Company</u> _____ **Group #**_____
Name of policyholder _____ **ID #** _____
Employer _____ **Policyholder's SS #** _____ **Policyholder's Birth date**_____
Relationship to policyholder: _ Self _ Spouse _ Child _ Other (please specify: _____)

****

How did you hear about us? <u>Provide name, address and phone so we may send a thank you!</u>
Doctor: _____
Hospital: _____

Insurance Plan: _____
Family: _____
Internet: _____ **ZocDoc**: _____
Friend: (Name) _____ **Other** (Please Specify):_____

HISTORY AND PHYSICAL

CHIEF COMPLAINT (Problem):_____

Onset date when condition started or injury: _____

Location: Right, Left, Bilateral Foot or Ankle: _____

How long have you suffered with pain? _____

Information Must Be Provided:

Height: _____ Weight: _____ Shoe Size: _____ Shoe Width: _____

MEDICAL HISTORY

___Diabetes ___Hypertension ___Nervous Condition ___Stroke

___Hypotension ___Hyperthyroidism ___Seizure Disorder ___Bleeding Disorder

___Heart Disease ___Rheumatic Fever ___Skin problems ___Sickle Cell Anemia

Other Health Problems Not listed:

_____

_____

Past Surgical History in the Last Five Years:

_____

_____

Please List all Medication you are taking:

_____

_____

Allergies to Medications:

___Penicillin ___Cephalosporin ___Sulfa ___Xylocaine/Lidocaine

___Iodine ___Latex Gloves ___Tape ___Tetanus

___Aspirin ___Codeine ___Sulfites

Please list all other Allergies not listed: _____

Family History:

___Diabetes ___Hypertension ___Heart Problems ___Circulatory ___Bleeding

Social History:

Do you use Tobacco? Y/N **Did you Smoke?** Y/N **Yrs. Quit** _____ **How Much?** _____

How many years? _____ **Do you drink Alcohol?** Y/N **Did you Drink?** Y/N

Estimate # of drinks per day/week/month? _____

Occupation: _____

Physical/Athletic Activities: _____

Females Only: Are you pregnant? Y/N Could you be pregnant? Y/N Are you nursing? Y/N

Last Menstrual Cycle: _____

Consent to use or Disclose Medical Information

I authorize NOVA FOOT & ANKLE CENTER to use and disclose the health and medical information of _____ for the following purposes. (Patient's Name)

o **Treatment** (Includes performed by a physician or other health care provider directly delivering care to you, coordinating or managing care provided to you with third parties, and consultation with and between physicians and other health care providers.)
o **Payment** (Includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management of activities including review of health care services for medical necessity, justification of charges precertification and preauthorization of services.)
o **Health Care Operations** (Includes the necessary administrative and business functions of your health care provider.
o **Other** (list family, friends, etc. who you would like to have access to your protected health information) _____

You may review our **"Notice of Privacy Practices"** for additional information about the uses and disclosers of information described in the CONSENT prior to signing the CONSENT.
Please verify that you have received a copy of our **Notice** by placing your initials here: _____
Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the **Notice** may change also. We will post a copy of the **Notice** in the lobby of our office, and will offer you a copy of the **Notice** on your first visit to us after the effective date of the then current Notice. We will also provide you a copy of the **Notice** upon your request.
As more fully explained in the **Notice**, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment and health care operations purposes. **We are not required to agree to your request.** If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment.

You have the right to revoke this CONSENT provided that you do so in writing, except to the extent that we have already used or disclosed the information in reliance with this CONSENT.

_____ _____
(Signature of patient, parent or guardian) (Date)

Financial Policy

Thank you for choosing our practice! We are committed to providing you with quality podiatric care. We have developed this payment policy to assist you in understanding our financial practices. Please read it carefully and sign in the space provided.

Insurance

We participate with many insurance plans, including Medicare and Medicaid. If you are not insured by a plan we do business with or you do not have insurance, payment in full is expected at each visit. Your insurance benefit is a contract between you and your insurance company. Knowing your insurance benefits is your responsibility. Please contact your insurance carrier with questions regarding your coverage. We must emphasize that as a medical care provider, our relationship is with you, our valued customer, not your insurance company.

If you have insurance coverage, you must present a valid insurance card at each visit. We will keep a copy of the most recent insurance card in your medical record. If your insurance coverage changes, you must notify us as soon as possible to avoid delay in your claims processing. If you fail to inform us of updated insurance, balance on unpaid claims will become your responsibility.

You are responsible for the deductible and estimated co-payments (includes office visit and procedure co-pays), co-insurance and deductibles must be paid for at the time of service. This is part of your contract with your insurance company.

Non-Covered Services

Please be aware that some of the services you receive may be non-covered by your insurance carrier. These services must be paid for at time of visit. Please read your enrollment booklet.

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.

Payment

For your convenience, we accept cash, checks, and most major credit cards including: VISA, MasterCard, American Express, Discover, and Debit Cards. We reserve the right to refer your account to a collection agency if your account is over 90 days past due. Failure to make payment will result in your account being sent to collections. **I understand that in the event my account becomes past due (over 90-days) and all attempts to arrange payment have failed, my account will be turned over to a collection agency and /or attorney. I understand that I will be responsible for all collection agency fees (30%) of total past due amount and all other costs expanded to the collection said amount.**

Returned checks will be subject to a collection fee of $35.00.

A 24 hour notice is required if you are unable to make your appointment to avoid a **$25.00 Cancelation charge. There is a $50.00 charge for No Show appointments.** This charge is payable by you and will not be billed to your insurance. If you think you will be more than 30 minutes late for your appointment, we will be glad to reschedule you for another time.

Thank you for understanding our payment policy. Please let us know if you have any questions.
I have read and understand the payment policy and agree to abide by its guidelines:

_____	_____	_____
Signature patient, parent or guardian	Date	Print Name

NOVA FOOT & ANKLE CENTER (NFAC)
NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used, disclosed and how you can access this information. Please review it carefully.

At the NOVA Foot & Ankle Center we will always keep your health information secure and confidential. We take precautions to secure electronic information. Firewalls and passwords are in place. A new law requires that we continue to maintain your privacy, give you this notice and follow the terms of this notice.

The law permits our office to use or disclose your health information to those involved with your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company in order to be reimbursed for services.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. The NFAC has a written contract with each business associate that requires them to protect your privacy.

We may use information to contact you. For example, we may send newsletters or other information to the address you have provided us with. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone..

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

With the exceptions as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you to the requested office.

You have the right to see and receive a copy of your health information, with a few exceptions you will be required to give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. You will be required to make the requested changes in writing. If you wish to include a statement in your file, please give it to us in writing.

We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add the new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

Acknowledgement

I have read the above and I am aware that a copy of the NOVA Foot & Ankle Center Notice of Privacy Practices is available per my request.

Signed: _____ Print Name:_____

If signing as a parent or guardian, please note the name of the patient: _____

Date: _____