The Foot & Leg SPECIALTY CENTER
6543 Madison St. New Port Richey, FL 34652
Phone: 727-842-9504 Fax: 727-842-9505

Patient Information and Consent

Patient Name: _____ **Birth Date**:_____/_____/_____ **Age:**_____

Address: _____ **City:** _____**St**:_____ **Zip:**_____

Alternate Address: _____

Phone Number:_____ **Cell:** _____ **Gender :** M_____F_____

Would you prefer reminder calls by ☐ **Phone** ☐ **Text Message?**

SSN#_____ **Marital Status: __ Married__Single__Widow __Other**

RACE: _____ African American _____ American Indian or Alaskan _____ Asian _____Hispanic _____ Mixed Race

_____ White_____ Other

Ethnicity: _____ Hispanic _____ Not Hispanic _____Refuse to report

How were you referred to our office? (Please circle) Family member Phonebook Newspaper Insurance Internet

Patient _____ Doctor_____other _____

Weight _____ **Height** _____ inches

PRIMARY CARE DOCTOR: _____

CARDIOLOGIST: _____

DIABETIC DOCTOR: _____

Emergency Contact _____ **Phone Number** _____

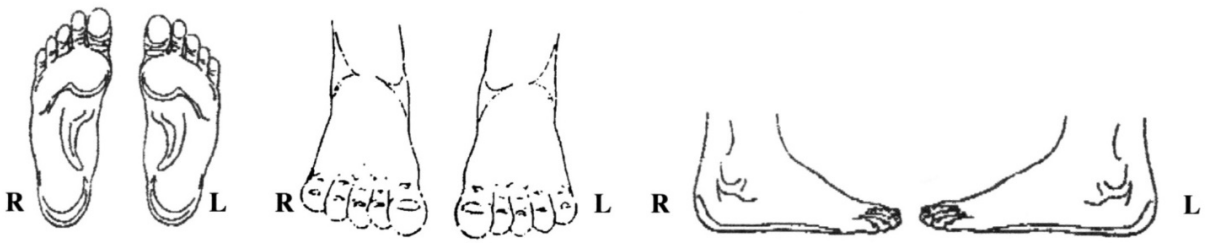
Relationship: _____

Do you want access to your online medical records through our office? _____Yes _____No

If YES, please provide a valid Email Address: _____
You will receive an invite via the email provided above for the patient portal. You will also have access through Apple Health.

**Briefly describe the reason for your visit today: _____
**Please rate your Pain level 1 to 10, 10 being the worst _____

MARK THE AREA (S) BELOW TO IDENTIFY ANY PROBLEMS YOU MAY BE HAVING



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CONSENT & FINANCIAL STATEMENTS

Insurance and Authorization

I certify that the information I have provided is correct. I also understand that the Foot & Leg Specialty Center files my insurance as a courtesy. I understand that I am responsible for my deductible. Co Payments, co-insurance or Non-covered services that will be collected at the time of service and or due within 60 days of insurance processing. .

Patient or Authorized Person's Signature **Date**

_____ _____/_____/_____

Policy Holder's name: _____ **Self** **Spouse** **Dependent**

DOB _____

SELF PAY If you are a self-pay patient; you will be required to pay $100.00 for the office visit before services are rendered.
In addition, any remaining balance on your account will be collected at end of your appointment.

Patient consent for Treatment

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by the Foot & Leg Specialty Center, Dr. Omair Zafar, DPM and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I understand that no guarantee has been or can be made as to the results of the treatments or examinations at The Foot & Leg Specialty Center/James V Stelnicki, DPM PA.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment, treatment and health care operations consistent with the Foot & Leg Specialty Center notice of privacy practices, financial policy notice and release of information.
3. I authorize payment of medical benefits to The Foot & Leg Specialty Center/James V Stelnicki, DPM PA or their designee for services rendered.
4. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

_____ _____

Patient or Authorized Person's Signature Date

HIPPA Policy: If you would like information released: (family member, spouse, significant other, doctors office, etc.)

All patients are protected under the Federal Health Insurance Portability and Accountability Act .The federal law prohibits staff from discussing your medical information, appointments, tests and or treatment with anyone other than the patient, unless authorize a release of my protected health information to

_____ _____ Relationship