The Foot & Leg SPECIALTY CENTER

6543 Madison St. New Port Richey FL 34652
Phone 727-842-9504 Fax 727-842-9505
footlegspecialtycenter.com
doctor@footlegspecialtycenter.com

Patient Information and Consent

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

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

Alternate Address: _____

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

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 _____Prefer not to report

Ethnicity: _____ Hispanic _____ Not Hispanic _____Prefer not to report

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

Patient _____ Doctor_____other _____

Weight _____ **Height** _____

PRIMARY CARE DOCTOR: _____

CARDIOLOGIST: _____

DIABETIC DOCTOR: _____

Emergency Contact _____ **Phone Number** _____

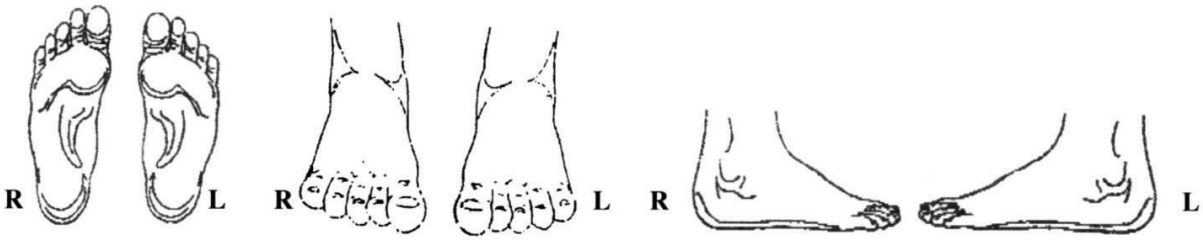
Relationship: _____

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.

****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



Patient Informed Consent

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 $120.00 for the office visit before services are rendered. In addition, any remaining balance on your account will be collected by the 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 _____

_____ _____

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

LIST OF CURRENT MEDICATIONS:

NAME	DOSAGE	FREQUENCY

LIST OF ALLERGIES:

_____

_____

_____

_____

_____

_____ _____

Patient or Authorized Person's Signature Date

Cancellation Policy and No-Show Policy
For Doctor Appointments and Surgeries

Cancellation/No Show Policy for Doctor Appointment

We understand there are times when you must miss an appointment due to emergencies or obligations for work, family, etc. However, when you do not call to cancel an appointment, you could be preventing another patient from getting much needed treatment. Therefore, the situation may arise where another patient fails to cancel their appointment and we are unable to schedule you for a visit, due to a "full" appointment book schedule.

If an appointment is not cancelled at least 24 hours in advance you may be charged a $25.00 cancellation/no show fee. If you are more than 15 minutes late to your appointment you may have to reschedule your appointment.

This fee will NOT be covered under your insurance policy.

Cancellation/No Show Policy for Surgery

Surgeries require a large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If your surgery is not cancelled at least 2 days in advance you may be charged a $50.00 cancellation/no show fee. This fee will NOT be covered under your insurance policy.

Account Balances

We require that patients with self-pay balances have their account balances to zero ($0) PRIOR to receiving further services provided by our doctor and staff.

Patients whom have questions about their bills or who would like to discuss a payment plan, may call and ask to speak to our billing staff. Those staff members will than review the patients account and concerns.

Patient balances over $100.00 must make payment arrangements PRIOR to any future appointments being made.

_____ _____

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