Family Footcare, PC

Milton Stern, DPM - Randy Kaplan, DPM - Cindy Pavicic, DPM

Office Policy

Patients are expected to pay for their office visit at the time of service, unless we have verified that your health insurance covers office visits and will reimburse us directly. All copayments must be made at the time of service.

It is your responsibility to understand your insurance coverage. There are numerous types of insurance coverages available. If you are enrolled in a health maintenance organization (HMO) or some other type of managed care plan, you are required to have a written referral for each and every visit. We will not see you without your referral unless you are willing to pay for the visit. It is your responsibility to know your unique insurance requirements and arrange for your authorizations or referrals when necessary. Since we are not party to your agreement with your insurance carrier, it is not our policy to establish why they have not paid, or why they paid less that anticipated. You will need to contact your carrier directly for any questions regarding their reimbursement policies. You are personally responsible for any unpaid balances.

Many insurance policies require that you meet a specific annual deductible. In recent years deductibles can exceed $10,000. Payment of your deductible is your responsibility. We do not absorb your deductible. We expect payment or payment arrangements immediately upon notification.

Unpaid balances are due upon receipt of your statement, unless payment arrangements have been made. If a balance is past due and you wish to be seen in our office we reserve the right to not treat you unless payment is made or at least partial payment is made and a payment plan is established.

If you have been involved in a car accident or work related incident, it is your responsibility to notify this office and provide authorization and bill information from your auto or worker's compensation carrier. We must have this information prior to your being seen.

Termination of care will result if your account becomes three months delinquent. We will bill your insurance company for most services; however, you are directly responsibile for your account should your insurance comapny fail to pay us. Accounts not receiving any payments for over 6 months are subject to be sent to collection or settled in small claims court.

We reserve the right to settle any disputes with our office both financial and medical with binding arbitration.

We now use text messaging, e-mail and phone calls to notify you of your appointments, any current specials and account balances. E-mail is our preferred method. We never share or sell any e-mails in our system.

We offer discounts on monies owed if paid through our Solution Reach Portal!

STARTING JULY 2017 THERE WILL BE A $35.00 FEE CHARGED TO YOUR ACCOUNT IF YOU MISS AN APPOINTMENT.

Cell Phone: _____

Home Phone: _____

E-mail: _____

I have read the above office policy and agree to their terms.

Patient Signature: _____ Date: _____

29355 Northwestern Hwy. Suite 110 Southfield, MI 48034 (248) 945-1000 Fax: (248) 945-1001

Family Footcare, PC

Milton Stern, DPM - Randy Kaplan, DPM - Cindy Pavicic, DPM

Patient Registration

Date: _____

Name: _____

Address: _____

City: _____

State: _____ Zipcode: _____

Date of Birth: _____

SSN: _____

Home Phone: _____

Cell Phone: _____

E-Mail: (Very important to us)

_____

How did you hear about us?

_____

Marital Status: _____

Gender: M F

Employer Name: _____

Work Phone: _____

Family Physician: _____

Phone: _____

Diabetic Physician (if you have one) _____

Phone: _____

Use this section if insurance is in patient's name.

Primary Insurance: _____

Insurance Numbers: _____

Secondary Insurance: _____

Insurance Numbers: _____

Use this section if insurance is in someone elses name.

Primary Insurance: _____

Insurance Numbers: _____

Secondary Insurance: _____

Insurance Numbers: _____

Insured relationship to patient: ☐ Spouse ☐ Child ☐ Parent Other: _____

Insurance Verification: **Office Use: Do not fill out**

Is insurance active? Y N Co-pay: _____ Encounter Fee: _____ Deductible: _____

Is referral needed? Y N Do we have one? Y N Orthotics covered? Y N

Any restrictions to foot care? _____

Verified by: TM CM Other: _____ Date: _____

29355 Northwestern Hwy. Suite 110 Southfield, MI 48034 (248) 945-1000 Fax: (248) 945-1001

Family Footcare, PC

Milton Stern, DPM - Randy Kaplan, DPM - Cindy Pavicic, DPM

Patient History

Name: _____ Date of Birth: _____ Age: _____

Vitals: Last Blood Pressure _____ Last Blood Sugar _____ Height _____ Weight _____

Race: ☐ Asian ☐ American Indian ☐ Black(African American) ☐ Hispanic ☐ White

Other: _____

Drinking Status: ☐ None ☐ Social ☐ Moderate ☐ Heavy ☐ Former Drinker

Smoking Status: ☐ Never Smoked ☐ Smoke 1-5 times/day ☐ Smoke > 5/day ? PPD _____

☐ Former Smoker- How many years ago? _____ How many packs/day? _____

Current Medications: ☐ I currently do not take any medications.

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

If you take more than 11 medications please list on a separate sheet.

Allergies: ☐ No known Allergies

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

If you have more than 9 allergies please list them on a separate sheet.

29355 Northwestern Hwy. Suite 110 Southfield, MI 48034 (248) 945-1000 Fax: (248) 945-1001

Medical History: ☐ Alcoholism ☐ Blood Disorders ☐ Circulation problems ☐ Muscle pain
☐ Breathing issues ☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease
☐ Asthma ☐ Heart Murmur ☐ Stomach/Bowel issues ☐ Depression ☐ Anxiety Disorders
☐ Mental Illness ☐ Kidney Issues ☐ Blood Clots ☐ High Choesterol ☐ High Blood Pressure
☐ Cancer ☐ Hepatitis ☐ Neuropathy ☐ Thyroid Disease ☐ Diabetes ☐ Arthritis
☐ HIV ☐ Skin Disorders ☐ CVA ☐ Stroke

Please add description or any other medical condition not listed.

_____

_____

Surgical History: ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts
☐ Joint Replacement ☐ Vascular Surgery Other Surgery: _____

_____

Foot or Ankle surgery: _____

_____

Occupational history: ☐ Retired ☐ Unemployed presently I ☐ walk ☐ stand ☐ sit at work

Job Descrition: _____

Excercise Level: ☐ I never excercise ☐ I excercise 1-3 times per week ☐ 4-7 times per week

Please describe your excercise routine. _____

_____

_____

Family History: Is there and blood relation that suffers from the list below.? Please tell us what relation.

Alzheimers _____ Arthritis _____ Blood Clots _____
Bleeding Disorders _____ Cancer _____ Cateracts _____
Circulation Problem _____ Depression _____ Diabetes _____
Emphysema _____ Heart Disease _____ Hypertension _____
Neurologic _____ Strokes _____

Any other medical conditions run in your family? _____

_____

Review of Systems: Circle if you have any of these symptoms or circle **"NONE"**

Cardiovascular	leg pain when walking fever chest pain/pressure leg swelling cold hands/feet fainting palpitations vascular disease valve problems **NONE**
Genitourinary	blood in urine hesitancy incontinence increased urgency decreased frquency excessive urination kidney disease kidney stones **NONE**
Gastrointestinal	abdominal pain heartburn blood in stool vomiting ulcers constipation diarrhea trouble swallowing decreased appetite increased appetite **NONE**
Integumentary	athletes foot nail abnormalities keloids itchiness dry, scaly skin **NONE**
Hematological	lower leg ulcers sickle cell disease anemia blood thinners clotting disorders **NONE**
Neurological	tingling weakness seizures numbness headaches tremors paralysis **NONE**
Musculoskeletal	back pain joint swelling muscle weakness muscle pain neck pain sciatica joint stiffness joint pain joint instablitiy arthritis **NONE**
Respiratory	chest pain wheezing COPD coughing snoring shortness of breath emphysema **NONE**

The above information is correct to the best of my knowledge. I understand that throughtout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed on this form.

Patient Signature: _____ Date: _____

Family Footcare, PC

Milton Stern, DPM - Randy Kaplan, DPM - Cindy Pavicic, DPM

Chief Complaint

Date: _____

Reason for Todays Visit

Patient Name: _____ Age: _____ Wgt: _____ Hgt: _____

Problem: _____

Location: _____

When did it start? _____ (How many?) Days Weeks Months Years Mode of onset? ☐ Acute ☐ Chronic

Timing of pain: ☐ Constant ☐ Morning ☐ Night ☐ As day goes on ☐ Activity related ☐ With walking

☐ With running/excercise ☐ Gets better with activity ☐ Start up pain Other: _____

Is the problem: ☐ Getting better ☐ Worse ☐ Staying the same Scale: 1 2 3 4 5 6 7 8 9 10

Is there swelling? ☐ Yes ☐ No Keeps you up at night? ☐ Yes ☐ No

Is there stiffness? ☐ Yes ☐ No Any clicking, laxity, giving out ☐ Yes ☐ No

Pain quality: ☐ Sharp ☐ Aching ☐ Stabbing ☐ Throbbing ☐ Burning ☐ Tingling _____

What makes the pain better? _____

What makes the pain worse? _____

Previoius Treatment

Have you had a similar condition in the past? ☐ Yes ☐ No _____

Have you seen another physician for this? ☐ Yes ☐ No Who?: _____

Did you go to the ER or an urgent care for this? ☐ Yes ☐ No _____

Have you had any testing for this? ☐ Yes ☐ No

☐ X-ray ☐ MRI ☐ CT ☐ Bone Scan ☐ Nerve Conduction Other: _____

Have you had an injection for this? ☐ Yes ☐ No How many?: _____

Have you gone to physical therapy? ☐ Yes ☐ No Did it help? ☐ Yes ☐ No

Have you had to use a mobility aid for this? ☐ Yes ☐ No

Which ones? ☐ Wheel chair ☐ Cane ☐ Walker ☐ Crutches ☐ Scooter Other: _____

Have you been immobilized? ☐ Yes ☐ No

Cast / # weeks _____ Cam Boot/ #weeks _____ Brace/ # weeks _____ Night Splint/ # weeks _____ ☐ Orthotics

Have you had surgery for this? ☐ Yes ☐ No Who, what and when? _____

Anything else we need to know? _____

If you have more that 1 complaint ask for additional sheet.

29355 Northwestern Hwy. Suite 110 Southfield, MI 48034 (248) 945-1000 Fax: (248) 945-1001