

Central Ohio Comprehensive Foot Care, LLC
575 Copeland Mill Rd. Suite 2F
Westerville, OH 43081
Phone: 614-891-2828

Delaware Podiatry Center, LLC
359 W. Central Ave.
Delaware, OH 43015
Phone: 740-369-3071

Welcome To Our Practice

APPOINTMENT DATE: _____ **AM PM**

Gregory Stockfish, DPM

Noel Thurber, DPM

John Slomsky, DPM

Bryan Feldner, DPM

We have enclosed the initial paperwork that needs to be completed for new and previous patients that have not been seen in our office for over a year. Please complete these forms. You can mail or fax it ahead of time or you can bring it with you when you come for your appointment. Please arrive 10-15 min. ahead of your scheduled appointment time and allow approximately 45-60 min for your entire visit.

- Remember to bring your **insurance card and photo ID**. We will need to photocopy it.
- Call your insurance to make sure the doctor you are scheduled with a participating medical provider in with your plan.
- All HMO's must obtain a referral from your primary care physician prior to the visit. If we do not have one on file you will be responsible for your bill and will be required to sign a referral waiver. If you are not sure if your insurance plan requires a referral then you should call your customer service department.
- If patient is less than 18 years of age, a parent or legal guardian must be present for the visit.
- All fees are payable at the time of visit unless you are with a contracting insurance or payments arrangements have been made prior to your visit.
- All deductibles, copays and deposits are due at the time of visit. We accept cash, check, VISA and MasterCard. There is a service fee of \$25.00 for all returned checks.

☺Welcome to our Office☺

(TO BE UPDATED YEARLY OR WITH ANY INFORMATION CHANGES)

PATIENT INFORMATION

Patient Name: _____ Today's Date: _____
Patient's S.S. #: _____ Date of Birth: _____ Age: _____
SEX: M ___ F ___ Marital Status: S ___ M ___ D ___ W ___ Race: _____
Street Address: _____ Apt. No.: _____
PO Box: _____ City: _____ State _____ Zip Code: _____
Home phone: (____) _____ Cell/Pager number: (____) _____
Email Address: _____
Occupation: _____ Work phone: (____) _____
Emergency Contact: _____ Emergency Contact Ph: (____) _____
Primary/ Family Doctor (*First and Last*): _____
Pharmacy Name: _____ Location: _____

GUARANTOR / PARENT INFORMATION

Responsible Party Name: _____
Relationship to Patient: _____ Responsible Party Date of Birth: _____
Guarantor's Social Security Number: _____ - _____ - _____
Guarantor's Address: _____ Apt. No.: _____
City: _____ State _____ Zip Code: _____
Home phone: (____) _____ Cell/Pager number: (____) _____
Employer's Name: _____ Work Phone: (____) _____

PATIENT'S REFERRAL INFORMATION

<input type="checkbox"/> Doctor: _____ (First and Last name please)	<input type="checkbox"/> Friend/Family _____ Close to home/work	<input type="checkbox"/> Advertisement _____ Insurance
<input type="checkbox"/> Internet	<input type="checkbox"/> Phonebook _____ Office Staff	<input type="checkbox"/> Hospital: _____ <input type="checkbox"/> Other _____

PATIENT'S INSURANCE INFORMATION *Please provide Insurance Card and Photo ID to Receptionist

Primary Insurance Company's Name: _____
Phone Number (____) _____
Name of Policy Holder: _____ Date of Birth: ____/____/____
SS#: ____-____-____ Insurance ID Number: _____
Group Number: _____
Secondary Insurance Company's Name: _____
Phone number (____) _____
Name of Policy Holder: _____ Date of Birth: ____/____/____
Insurance ID Number: _____ Group Number: _____

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IMPORTANT OFFICE POLICIES

MEDICAL INFORMATION

I authorize *Central Ohio Comprehensive Foot Care, LLC/ Delaware Podiatry Center, LLC. to release the medical records concerning my son/daughter/self to any physician, hospital, or agency involved in the care of the patient listed.

ASSIGNMENT OF MEDICAL BENEFITS

I authorize my insurance carrier to assign all surgical and or medical benefits, if applicable, to the appropriate physician. I also authorize release of medical information necessary to process all medical insurance claims. It is your responsibility to inform the office of any insurance changes. in the event you do not do so you will be responsible for all charges incurred.

PAYMENT POLICY

Co-payments are to be collected at the time services are received. We accept cash, checks, Visa and MasterCard. All medical services provided are directly charged to the patient or responsible party. If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office. There is a **service fee of \$25.00 for all returned checks**. This is not payable by your insurance company.

CANCELLATION POLICY

Our office requests that if an appointment needs to be cancelled that we receive notice no later than 4 hours prior to the appointment. We reserve the right to charge \$25.00 for a "no show" appointment, to be collected on or before your next appointment.

INSURANCE POLICY:

You will need to have your insurance card with you at each visit as we may ask to see it to verify current insurance. Even though we may contract with your insurance, you are responsible for charges to your account.

REFERRAL POLICY

I understand that it is my responsibility to obtain a referral through my primary care physician's office if required by my insurance company. Failure to do so will result in charges being billed directly to myself.

MINOR POLICY

If the patient is under 18 yrs of age, they must be accompanied by a legal guardian or have the proper consent filled out in our office and kept on file.

Please Read and Sign:

I hereby authorize my insurance benefits to be paid directly to *Comprehensive Foot Care/Delaware Podiatry Center. I understand and am responsible for all charges including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Print Name: _____

Signature of Responsible Party: _____ Date: _____

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Central Ohio Comprehensive Foot Care/Delaware Podiatry Center may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). Please ask to see the Notice of Privacy Practices for more complete description of such uses and disclosures. With my consent, Central Ohio Comprehensive Foot Care/Delaware Podiatry Center may call or send information as indicated below to carry out TPO, such as appointment reminders, insurance items pertaining to my clinical care, including laboratory results among others.

With my consent Central Ohio Comprehensive Foot Care/ Delaware Podiatry Center may:

- Call me at my home? Yes No
- May we leave a message on a machine at home? Yes No
- Call me at work? Yes No Retired
- May we leave message on voice mail at work? Yes No Retired

With my consent, Central Ohio Comprehensive Foot Care/ Delaware Podiatry Center may give appointment information, account information, results of test and/or surgery to family members listed below:

Name: Relationship:

1) _____

2) _____

By signing this form, I am consenting to Central Ohio Comprehensive Foot Care's/ Delaware Podiatry Center's use and disclosure of my PHI to carry out TPO and confirming that I have read the office policies. I also have received/reviewed a copy of the financial policy.

Print Patient Name: _____ Date: _____

Signature of Patient or Legal Guardian: _____

* Central Ohio Comprehensive Foot Care, LLC and Delaware Podiatry Center, LLC are separate entities.

REASON for VISIT

Please list your present foot or ankle concerns, problems or symptoms: _____

MEDICAL HISTORY

When was your last physical exam? _____

Physician's First & Last Name: _____ Phone: _____

Height: _____ Weight: _____ Shoe Size: _____

1) Are you currently under medical treatment? Yes No

Please describe: _____

2) Have you ever had any serious illnesses

or operations? Yes No

Please describe: _____

3) Are you currently taking any medication? Yes No

Please list: _____

7) Have you had any allergic reactions to the following:

Local Anesthetics (e.g. Novacaine) Yes No

Penicillin or other antibiotics Yes No

Sulfa Drugs Yes No

Barbiturates Yes No

Sedatives Yes No

Iodine Yes No

Aspirin Yes No

Other Yes No

Please describe: _____

4) Do you smoke? Yes No

5) Do you use alcohol? Yes No

6) Do you use cocaine or other drugs? Yes No

8) Women Only:

Do you have regular periods? Yes No

Are you taking birth control? Yes No

Have you ever been pregnant? Yes No

Number of pregnancies: _____

Have you ever had the following:

Anemia(low blood count)...	Yes	No	Heart Disease.....	Yes	No	Prostate Problem.....	Yes	No
Anorexia (no appetite)	Yes	No	Heart Murmur.....	Yes	No	Psychiatric Care.....	Yes	No
Arthritis.....	Yes	No	Hernia.....	Yes	No	Respiratory Disease....	Yes	No
Asthma.....	Yes	No	Herpes.....	Yes	No	Rheumatic Fever.....	Yes	No
Back Problems.....	Yes	No	High Blood Pressure	Yes	No	Scarlet Fever.....	Yes	No
Bleeding Tendency.....	Yes	No	HIV/AIDS.....	Yes	No	Shortness of Breath.....	Yes	No
Blood Disease.....	Yes	No	Jaundice.....	Yes	No	Sinus Trouble.....	Yes	No
Cancer.....	Yes	No	Kidney Disease.....	Yes	No	Skin Rash.....	Yes	No
Chemical Dependency(addiction to drugs)			Latex Sensitivity.....	Yes	No	Stroke.....	Yes	No
	Yes	No	Liver Disease.....	Yes	No	Thyroid Problems.....	Yes	No
Chemotherapy.....	Yes	No	Low Blood Pressure.....	Yes	No	Tonsillitis.....	Yes	No
Chicken Pox.....	Yes	No	Measles.....	Yes	No	Tuberculosis.....	Yes	No
Chronic Fatigue Syndrome	Yes	No	Migraine Headaches.....	Yes	No	Ulcer.....	Yes	No
Circulatory Problems.....	Yes	No	Mitral Valve Prolapse.....	Yes	No	Venereal Disease.....	Yes	No
Congenital Heart Lesion.	Yes	No	Mumps.....	Yes	No	Any other conditions please describe:		
Cough persistent or bloody	Yes	No	Multiple Sclerosis.....	Yes	No	_____		
Diabetes.....	Yes	No	Pacemaker.....	Yes	No	_____		
Emphysema.....	Yes	No	Pneumonia.....	Yes	No	_____		
Epilepsy.....	Yes	No	Polio	Yes	No			
Glaucoma.....	Yes	No						
Hepatitis Type.....	Yes	No						

Rev.: 7-20-11

Name: _____ Date: _____