Foot Health Center
Robert Kadish, D.P.M.

Today's Date __________

Full Name____ **Male / Female**

Address ______________________________ **City** ____________ **State** ____ **Zip** _____

Date of Birth ____/____/____ **Age** ______

Cell # ________________**Home #**_______________ **Work #** ________________

Email Address: ____

Pharmacy name, Street & Phone #______________________________________

Marital Status: Circle one

Divorced / Married / Single / Widow / Partner

Employment Status: Circle one **Occupation?** ______________________________

Part time / Full time / Not Employed / Student

How did you hear about us? Circle One

Internet / Friend / Yellow Pages / Sign Outside

TV / Advertisement / Doctor ______________________

Emergency Contact Name & Number ____

Shoe Size ______**Weight** ______**Height** ______

Primary Care Physician's Name:____

Reason for seeing Dr. Kadish today? (Please circle all that apply)

Right foot / Left foot / Right & Left Foot / Toe Pain / Fungus Toenail(s) / Heel Pain / Itching

Burning / Numbness / Injury / Work Injury / Ingrown Toenail / Fungus Toenail(s) / Arch Pain

Pain in Ball of Foot / Wart(s) / Callous / Bunion / Athletes Foot / Diabetic Foot Exam

Ankle Pain / Other ______________

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Allergies: Circle all that apply

No Known Drug Allergies / Penicillin / Sulfa Drugs (Bactrim)/ Amoxicillin / Keflex / Codeine

Latex / Cipro / Iodine / Aspirin / Ibuprofen / Cortisone / Tape / Other ____________________

Medication Regulations Require a List or a Copy:
Please List ALL Prescription Medications, Over the Counter Medication, & Vitamins:

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Medical History: Circle any you have or have had a problem with.

Diabetes / Gout / Heart Attack / Hepatitis / HIV / Kidney Disease / Cancer- Type: __________

Neuropathy / High Blood Pressure / High Cholesterol / Vascular Disease / Arthritis

Liver Disease / Blood Clots / Thyroid Disorder / None / Other ________________________

Last Blood Sugar Level? (if Diabetic) ______

Surgical History: Circle all that apply

Foot / Eye / Tonsils / Thyroid / Amputation / Heart / Appendix / Gallbladder

Hernia / Hysterectomy / Breast / Knee / Shoulder / Wrist / None / Other _______________

Social History: Circle all that apply

Smoke Everyday / Smoke Some Days / Previous Smoker / None

Drink Everyday / Drink Some Days / Previous Drinker / None

Family History: Circle all that apply

Heart Disease / Diabetes / Cancer / Kidney Disease / High Blood Pressure

High Cholesterol / Stroke / Other _________________

Foot Health Center
1521 N. Causeway Blvd.
Metairie, LA 70001

Consent for Assignment of Benefits and Treatment

I certify that me and my dependents have insurance coverage with the named carrier I have provided and hereby authorize the release of all medical information necessary to process insurance claim(s). I hereby assign and authorize direct payment of all medical and /or surgical benefits, including Major Medical, Private Insurance and other Health Plans to Dr. Robert Kadish, D.P.M. The above named practice, may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits. I grant permission for the above named Doctor and their Assistants to render care in the diagnosis / treatment of my foot conditions and release related information to my Physician as required by law. This Assignment will remain in effect until revoked by me in writing. A signed photocopy of this assignment will be considered as valid as an original.

Signature of responsible party (X) ________________________________ **Date** ________

Print Name_____________________________________

Patient Name (if different from responsible party) ________________________________

Acknowledgement of Receipt of Financial Policy

I acknowledge that I have read and understand the Financial policy. I understand that Dr. Robert Kadish, D.P.M. is not ultimately responsible for collecting from my insurance or negotiating settlement of claims.

I understand the financial policies and accept responsibility for payment of any balance owed on my account. And I am responsible for all charges whether or not paid by insurance.

Signature of Responsible Party (X) ______________________________ **Date** __________

Print Name ___________________________________

Patient Name (if different from responsible party) ________________________________

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices. I have read and understand the Notice. By signing this form, I am consenting Robert Kadish, D.P.M. to disclosure of my Personal Health Information to carry out treatment, Payment and Healthcare Operations.

Signature of Responsible Party (X) ________________________________ **Date** _________

Robert Kadish, D.P.M.
1521 N. Causeway Blvd. Ste: A
Metairie, LA 70001

Financial Policy

As insurance coverage decreases and the patient's financial responsibility increases, we understand the need for clear communication of our financial policies. To better service the needs of our patients, we added valuable tools to help you meet your increased medical expenses.

1. We will continue to look to insurance companies for their payment, and assist you in receiving proper reimbursement for our services. Unfortunately, most insurance companies no longer cover services fully and most current insurance plans chosen by our patients require significant out-of-pocket expenses to be paid by the patient.
2. Our staff has been trained to be able to communicate with you and answer your questions regarding payment and insurance reimbursement.
3. It is your responsibility to verify that all requirements of your insurance plan are met. It is ultimately your responsibility to verify whether any care you receive is covered by your insurance plan. It is important for you to verify your benefits and expenses of your plan.
4. In Accordance with the requirements of most insurance contracts, **we will require payment of office Co-Payments at each visit for any person being seen for treatment or service.** Your insurance company will be notified when this contractual payment is not paid at the time of appointment.
5. For patients owed balances, we offer credit card, debit cards, care credit, and checks. You must advise us of any payment you receive from insurance for our services and forward this amount to our office immediately.
6. If we are a contracted provider on your insurance plan, we will file a claim with your Insurance carrier and you will be billed when they have responded to our claim. Payment or denial, you will receive a statement for the amount your insurance company notifies us is your responsibility.
7. If Robert Kadish, D.P.M. is not a contracted provider for your insurance plan, we will file a claim with the information you provided and you will be billed when they have responded to our claim.
8. I understand that I have been notified that Robert Kadish, D.P.M. is a share holder in Advanced Surgery Center of Metairie and Pain Management Group LA, LLLP.
9. **If you do not have a insurance card with you, you will be billed for the entire amount and asked for payment at the time of service. We will not be able to file your insurance without a copy of your insurance card.**

Notice of Privacy Practices

I hereby give my consent for Robert Kadish, D.P.M. to use and disclose Protected Health Information about me to carry out Treatment, Payment and Healthcare Operations. I have the right to review the Notice of Privacy Practices prior to signing this consent. Foot Health Center reserves the right to revise it's Notice of Privacy Practices may be obtained by forwarding a written request to Foot Health Center 1521 North Causeway Blvd. Ste: A Metairie, LA 70001.
With this consent Foot Health Center may call my home or other alternative location and leave a message on voicemail or in person, such as appointment reminders, insurance, and any pertaining to clinical care. Including Laboratory results. However our policy is not to leave detailed messages regarding treatments, test results or Healthcare payments. With this consent, Foot Health Center may mail to my home or alternative location any items that assist the Practice in carrying out Treatment, Payment and Healthcare Operations, such as patient statements as long as they are marked Personal and Confidential. I have the right to request that Foot Health Center restrict how it uses or discloses My Protected Health Information. To carry out Treatment, Payment and Healthcare Operations. However, the practice is not required to agree to my requested restrictions, but it does, it is bound by this agreement. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Foot Health Center may decline to provide treatment.

Name (Print): ______________________________ Sign:___________________________ Date:_________