Foot Health Center, LLC
Robert J. Kadish, DPM
Abdul Latif Nurudeen, DPM
Metairie, LA / Laplace, LA

Today's Date_____

Name:_____**Male / Female**

Address:_____**City**_____**State**____**Zip**_____

Date of Birth____/____/____

Cell#_____**Work#**_____**Home#**_____

Email address:_____

Pharmacy name & city:_____

Marital Status: Married / Single / Divorced / Widowed / Partner

Any children? _____**if yes, how many?**_____**Whom do you live with?**_____

Employment status: please circle one: Full time / Part time / Not employed / Student

Occupation:_____

How did you hear about us? Internet / Friend / Yellow pages / Sign outside / TV / Doctor _____

Emergency contact name & number_____

Shoe Size:_____**Weight:**_____**Height:**_____

Primary Care Physician's Full Name & Last Date Seen:_____

_____

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

Right foot / Left foot / Toe pain / Toenail(s) fungus, / Heel pain / Itching / Burning / Numbness

Tingling / Injury / Work injury / Ingrown toenail / Arch pain / Pain in ball of foot / Wart(s)

Callous / Bunion / Athletes Foot / Diabetic foot exam / Ankle pain / Other_____

Do you drink caffeinated beverages?_____**If so, how much?**_____

Foot Health Center, LLC

Allergies: Please 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 medications, over the counter and any vitamins you are taking.

_____

_____

_____

Medical History: Please circle any you <u>have</u> or <u>had</u> a problem with

Diabetes / Gout / Heart attack / HIV / Hepatitis / Kidney disease / Cancer - Type _____

Neuropathy / High blood pressure / High cholesterol / Vascular disease / Arthritis / Liver disease

Blood clots /Thyroid disorder / Gastrointestinal problems / None / Other _____

Last blood sugar level (if diabetic)_____**A1C level (if applicable)**_____

Do you wear glasses, contacts, or both? _____

Surgical History: Please circle all that apply

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

Breast / Knee / Shoulder / Wrist / None / Other _____

Social History: Please circle all that apply

Smoke everyday / Smoke some days / Previous smoker / None

Drink everyday / Drink some days / Previous drinker / None

Family History: Please circle for each that applies

Heart disease (mother or father,) / **Diabetes** (mother or father) / **Cancer** (mother or father)

Kidney disease (mother or father) / **High blood pressure** (mother or father)

High cholesterol (mother or father) / **Stroke** (mother or father **Other**_____

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 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.

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 J. Kadish, DPM or Toddrick L. Tookes, DPM 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 J. Kadish, DPM is a share holder in Advanced Surgery Center of Metairie.

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 J. Kadish, DPM and or Toddrick L. Tookes, DPM to use and disclose Protected Health Information about me to carry out Treatment, Payment and Health Care Operations. I have the right to review the Notice of Privacy Practices prior to signing this consent. Foot Health Center, LLC reserves the right to revise it's Notice of Privacy Practices may be obtained by forwarding a written request to Foot Health Center, LLC 1521 N. Causeway Blvd., Ste: A Metairie, LA 70001. with this consent Foot Health Center, LLC may call my home or other alternative location and leave a message on voice mail 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 Health care payments. With this consent, Foot Health Center, LLC may mail to my home or alternative location any items that assist the practice in carrying out Treatment, Payment, and Health Care operations, such as patient statements as long as they are marked Personal and Confidential. I have the right to request that Foot Health Center, LLC restrict how it uses or discloses My Protected Health Information. To carry out Treatment, Payment and Health Care 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, LLC may decline to provide treatment.

Name (Print)_____ **Date**_____

Signature:_____