Adriana Strimbu, DPM, PA

404 N. Federal Hwy, Hallandale, FL 33009, Ph. (954) 455-9404, Fax (954) 455-9407

www.hallandalebeachfootdoctor.com

PATIENT INFORMATION

Name:_____ Date:____/____/_____

First name **Last name**

Address:_____

City:_____ State:_____ Zip:_____

Preferred Phone Number*:(_____)_____ Other Phone Number: (_____)_____

Appointment confirmation calls will always be made to the preferred phone number and a message with your appointment details will be left.

Birthday: ____/____/_____ Age: _____ SS# _____

Occupation: _____ Marital Status: ◯S ◯M ◯D ◯W

E-mail: _____

Primary Language: ◯English ◯Spanish ◯Russian ◯Other: _____

Ethnicity: ◯Hispanic/Latino ◯NonHispanic/nonLatino

Race: ◯American Indian/Alaska Native ◯Asian ◯Black/African American ◯Hawaiian/Pacific Islander ◯White

Referred by: _____

Primary Care Physician:_____ Ph: (_____) _____

Date of the last visit to your doctor:_____

Which ***Pharmacy*** do you use:_____

Address:_____

City:_____ State:_____ Zip:_____ Ph:(_____) _____

MEDICAL INSURANCE

Insurance's Name: _____ ID #: _____

Secondary Insurance: _____ ID#_____

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MEDICAL HISTORY

Reason for Visit: _____

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

Are you 50 years or older? _____ Yes _____ No

Have you ever been diagnosed with any of the following? (circle all that apply)

Diabetes **Chronic Kidney Disease** **High Blood Pressure** **High Cholesterol**

Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatique, tingling, cramping or pain) when you walk which is relieved by rest? _____ Yes _____ No

Do your toes or feet look pale, discolored or bluish? _____ Yes _____ No

Do you have pain in the legs and/or feet, or legs that heal slowly or not at all? _____ Yes _____ No

Does one leg or foot feels colder than the other one? _____ Yes _____ No

Has your doctor ever told you that you have diminished or absent foot pulses? _____Yes _____No

Poor nail growth and decreased hair growth over time on toes and legs? _____ Yes _____ No

Have you ever worn custom made arch supports (orthotics)? _____Yes _____No

Do you smoke you smoke? _____ Yes _____ No

if **Yes**, when did you start: _____ How much? _____

If **No**, did you ever smoke? _____Yes _____No → if **Yes**, when did you start: _____ and stopped: _____

Do you drink alcohol? _____ Yes _____ No if Yes, how much: _____

Do you drink coffee? _____ Yes _____ No if Yes, how much: _____

Do you participate in any physical activity? _____Yes _____ No if Yes, What type: _____

How often: _____

ALLERGIES: (please circle all the ones that apply)

NONE LOCAL ANESTHETICS PENICILLIN ASPIRIN ADHESIVE TAPE

LATEX SULFUR PRODUCTS CORTISONE CODEINE OTHER(s): _____

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MEDICAL HISTORY

ILLNESSES: (Please check all that apply)

AIDS / HIV	Back Problems	High blood pressure	Numbness/Burning in feet
Anemia	Bleeding Disorders	High Cholesterol	Poor circulation
Arthritis	Gout	Kidney problems	Stroke
Artificial Heart Valves	Heart Disease	Liver disease	Pacemaker
Artificial Joints	Headaches	Lung problems	Defibrilator
Asthma	Hepatitis	Neck pain	Diabetes
Circulatory problems	Glucoma	Cataracts	Depression / Anxiety

Cancer: _____ Other: _____

Please list any **MEDICATIONS** that you are currently taking: _____

_____

_____

_____

Please list any ***OPERATIONS/SURGERIES*** that you had had: _____

_____

_____

FAMILY HISTORY:

Mother _____ Father _____

Sister _____ Brother _____

I hereby give my permission to the doctor at the Adriana Strimbu, DPM, PA to perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in diagnosis and/or treatment of my feet and/or ankles.

PATIENT SIGNATURE: _____ **DATE:** _____

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FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our financial fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

PATIENTS BILLING: All patients are responsible for **all co-payments, co-insurance, or deductible amounts at the time of service.** This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payment and deductibles from patients can be considered fraud. As a courtesy, our office does verify benefits with your insurance carrier; howerever, the insurance agreement is a contract between you and your insurance carrier. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If you do not have health insurance you are responsabile for the full payment at the time of service. If you are not insured by a plan we participate with, payment in full is expected at each visit.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit as specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. It is your responsibility to contact your primary care physician to obtain your referral and bring it to our office for your visit or have them fax it to our office. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all the services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 24 hours of this visit. You will also be given the option to reschedule your appointment.

MEDICARE: We are a participating Medicare provider. We accept Medicare benefit amounts. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsabile for paying their annual deductible if it has not yet been met. You are also responsible for any compayments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for **full payment of these services at the time of service.**

NON-CUSTOM DURABLE MEDICAL EQUIPMENT RETURNS: If a patient is unsatified with any non-custom Durable Medical Equipment item, it must be returned within 30 days per Medicare guidelines. Returns after 30 days will not be permitted. The item will only be accepted as a return if it shows signs of no wear and must have the original wraping or box.

REGARDING MINORS: The adult accompanying a minor, and his/her parent(s) or guardian(s) are responsible for FULL payment at the time of services. Non-Emergency treatment will be denied unless charges have been pre-authorized to an APPROVED agreement.

CANCELLED/MISSED APPOINTMENTS: Unless cancelled at least 24 hours in advance, our policy is to charge $25 for any missed appointment. If you miss 3 or more appointments, you may be required to pay a $50 deposit to hold any future appointment time slots. If you arrive late for an appoinment, we may need to reschedule your appointment. You will bear complete financialy responsibility for any fee incurred. Repeated missed or late appointments may result in dismissal from our practice. Please help us serve you better by keeping schedule appointments.

METHOD OF PAYMENT/COLLECTION FEES: We accept the following payment methods: cash, check or Visa/Mastercard. An additional $25 fee will be added to your statement if the check is returned from your bank. In the event that the insurance company sends payment to you, the patient, it shoud be forwarded to our office to be applied to your balance.

You will be sent up to 3 notices for your financial responsibility(co-insurance, deductible) after payment and /or explanation of benefits (EOB) is received from your insurance company. After the 3rd and last notice, your account will be forwarded to our collection agency. If your account is sent to a collection agency, a 35% fee will be added to your account. You bear complete financial responsibility for any fees incurred.

I have read the above policy regarding my *financial responsibility* to Adriana Strimbu, DPM, PA for medical services provided. I agree to pay Adriana Strimbu, DPM, PA any balance unpaid by my insurance carrier for myself or the below named person.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have (or had the opportunity to read if so choose) and understand the Notice and agree to its terms.

Assignment of Benefits: I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Adriana Strimbu, DPM, PA** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees **AT THE TIME OF SERVICE.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize Release of Medical Information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms.

PRINT Patient Name: _____ **Date:** _____

Patient's Signature: _____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: _____ **Signature:** _____

Relationship to Patient: _____ **Date:** _____