Section I: **Patient Information**

Name: _____ Referring provider: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____)_____

Preferred form of contact: □ Home phone □ Work phone □ Cell phone

Email Address: _____ Are you: □Employed □ Retired

Date of Birth: ____/____/_____ Social Security: _____ (office policy requires a social security number)

Check Appropriate Box: □ Minor □Never married □ Married □ Widowed □ Domestic Partner □ Divorced

If Student, Name of School: _____ City/State: _____ □ FT □ PT

Spouse or Parent's Name: (circle) _____ Phone: (___)_____

Whom may we thank for referring you? _____

Emergency Contact_____ Relationship _____ Phone: (____)_____

Primary Language: □English □ Spanish □ Other _____ _____

Race/ Ethnicity: □ Asian □ Black □Hispanic □White □Other Name of Primary Care Provider (Doctor)

Section II: **Responsible Party/ Guarantor**

Relationship to Patient: □ Self □ Spouse □ Parent □ Other Guarantor date of birth: _____

Name: _____ Relationship to Patient: _____

Address:_____ City: _____ State: _____ Zip: _____ Phone:(__)_____

Employer: _____ Work Phone (____) _____

Section III: **Insurance Information**

Name of Insurance Carrier: _____ ID#_____ Group#_____

I authorize the release of any medical information necessary to process this claim to my insurance company, and request payment of benefits to DR. GRABOWSKI, PC.
I acknowledge that I am financially responsible for payment whether or not covered by my insurance.

PATIENT: _____ _____ _____/___/_____
Signature Please Print Date

GUARANTOR: _____ _____ _____/___/_____
Signature Please Print Date

Date:	Name:		DOB:
Sex: Male Female	Height:	Weight:	Shoe Size:
Pharmacy:		Location:	Phone Number:

Allergies: O No known allergies O Penicillin O Aspirin O Sulfa O Local Anesthetic O Latex OAdhesive/Tape O Iodine Other_____

Current Medication: Include prescriptions, over the counter medications, and vitamins:

_____

Surgical History: Please list your major surgeries _____

_____

Social History:	
Tobacco History:	Alcohol History;
O Yes, I smoke ____ packs per day O Yes, I currently chew O No, I quit smoking/chewing ____ years/ ____ months ago O Never Smoked	O Never O Social O Light O Heavy, _____ per week O Quit, _____years/, ____months ago
Illicit Drugs: O No O Yes, type:_____	

MEDICAL HISTORY:			
Please check if you have ever been diagnosed with the following problems:			
O Aids/HIV	O COPD/Emphysema	O High blood pressure	O Parkinson's disease
O Alcoholism	O Depression	O High cholesterol	O Peripheral vascular disease
O Anemia	O Diabetes	O Kidney problems	O Psychiatric problems
O Angina	O Dialysis	O Liver problems	O Rheumatoid arthritis
O Asthma	O GERD	O Lupus	O Scoliosis
O Arthritis ("wear and tear")	O Gout	O MRSA	O Seizures
O Bleeding problems	O Heart attack	O Multiple sclerosis	O Stroke
O Blood clots	O Heart disease	O Obesity	O Thyroid disorder
O Cancer	O Hepatitis	O Osteoporosis or osteopenia	O Tuberculosis

Family History:

Medical problem:	Relation (e.g. mother, son)	Medical Problem:	Relation
Anesthesia problems		Heart Disease	
Arthritis		High blood pressure	
Cancer		Malignant hyperthermia	
Clotting Disorder		Sleep apnea	
COPD/Emphysema		Stroke	
Diabetes		Other:	
Addiction, type _____		Other	

DETAILED CURRENT MEDICAL HISTORY: Please indicate if you have the following. If your condition is not listed please feel free to write it in.

Constitutional:
Physical/Mental condition
◊ Addiction
◊ Anxiety
◊ Headache
◊ Major Trauma
◊ Nausea/Vomiting
◊ No to all above

Cardiovascular:
Heart/Blood Vessels
◊ Anemia
◊ Angina
◊ Bleeding Disorder
◊ Claudication
◊ High Blood Pressure
◊ High Cholesterol
◊ Leg Pain when Walking
◊ Murmur
◊ Pacemaker
◊ Peripheral
◊ Vascular Disease
◊ Phlebitis
◊ Poor circulation
◊ Stroke
◊ Swelling of the Foot/Ankle
◊ No to all above

Endocrine:
Glands/Hormones
◊ Cold Intolerance
◊ Diabetes
◊ Dry Hair/Skin
◊ Hyperglycemia
◊ Hypoglycemia
◊ Immunologic Problems
◊ No to all above

Ears, Nose, and Throat:
◊ Symptoms involving the Ear Nose, Mouth, and Throat
◊ No to all above

Eyes:
◊ Eye problems
◊ Glaucoma
◊ Vision Problems
◊ No to all above

Gastrointestinal:
◊ Constipation
◊ Diarrhea
◊ Heartburn
◊ No to all above

Genitourinary (GU)
◊ Kidney Dialysis
◊ No to all above

Immunologic:
(Immune System)
◊ Allergic/Immunologic System
◊ AIDS/HIV
◊ No to all above

Integumentary/Skin
◊ Athlete's Foot
◊ Cancer, Tumor, Cysts
◊ Corns/Callouses
◊ Dermatitis
◊ Eczema
◊ Excessive Scar tissue
◊ Fungus Nail/Skin
◊ Hives
◊ Ingrown Nails
◊ Lower Leg Ulcer
◊ Non-Healing Wound
◊ Plantar Warts
◊ Psoriasis
◊ Rash
◊ Shingles
◊ Skin Discoloration
◊ Ulceration
◊ No to all above

Hematologic/ Lymphatic
(Blood/Lymph Systems)
◊ Ankle Edema
◊ Leg Pain
◊ Leg Swelling
◊ No to all above

Muskulo/Skeletal
◊ Ankle Pain
◊ Arthralgia
◊ Arthritis
◊ Back/Neck pain
◊ Bunion
◊ Bunionette
◊ Fibromyalgia
◊ Flat Feet
◊ Fractured Ankle
◊ Fractured Foot
◊ Fractured Toes
◊ Gout
◊ Heel Pain
◊ Hip Pain
◊ Joint Pain
◊ Rheumatoid Arthritis
◊ Sciatica
◊ Scoliosis
◊ No to all above

Nervous System:
◊ Headache
◊ Hearing Problems
◊ Neurological Problems
◊ Numbness
◊ Seizure/Paralysis
◊ Thyroid Problems
◊ Tingling
◊ No to all above

Psychiatric:
(Mental State)
◊ Addiction
◊ Anxiety
◊ Depression
◊ No to all above

Respiratory:
◊ Asthma
◊ Bronchitis
◊ COPD
◊ Emphysema
◊ Lung Disease
◊ Sleep Apnea
◊ Tuberculosis
◊ No to all above

Vaccinations:

Flu Shot Date:	COVID Shot Date:	Tetanus Shot Date:
O Yes O No	O Yes O No	O Yes O No

CONSENT: I certify that the above information is correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures that may be deemed necessary in the diagnosis and treatment of my feet.

_____ _____

Patient/Guardian Signature Date

DR. GRABOWSKI PC.

RELEASE OF MEDICAL RECORDS

To protect your information and comply with HIPAA Standards, Dr. Grabowski PC requires all patients to provide us with a written request if you would like us to release your medical information.

I, _____ hereby authorize and give my permission for the office of Dr. Grabowski PC to disclose my private healthcare information to my insurance carrier, my medical providers, and:

_____

_____

_____

_____

◊ None

_____ _____

Patient Signature Date

DR. GRABOWSKI PC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the
Notice of Privacy or had the opportunity to request one.

Patient: _____ _____ _____/_____/_____
Signature Please Print Name Date

Guarantor: _____ _____ _____/_____/_____
Signature Please Print Name Date

DR. GRABOWSKI PC.

Cancellation and/or No-Show Policy Effective January 1, 2024

Many doctors, especially Family Practice, stack patients (book them into overlapping time slots) to avoid having large holes in their schedules. When our patients cancel with little or no notice or simply do not show up for their appointment, that time is wasted and there is no one to fill the hole. (If given proper notice, we are often able to fill it with someone from our length wait list).
Due to the increase of last-minute cancellations and no-shows in our appointment schedules, we have no choice but to implement the following:

Appointments that are cancelled without at least one business days' notice will be billed directly to the patient as follows:

*New Patient = $50.00
*Established Patient = $25.00

I have read the above policy, understand and agree to pay the penalty assigned to me if I should no-show or cancel my appointment without the required notice.

_____ _____/____/_____
Patient Signature Date

FINANCIAL POLICY FOR DR. GRABOWSKI PC

Thank you for choosing our office for your medical care. We are committed to serving you with the highest skill and quality. The podiatry care provided by DR. GRABOWSKI PC are services you have elected to receive and they may imply a financial responsibility on your part.

CO-PAYS: Co-pays are due at the time of service.

SELF-PAY: Payment in full is due at the time of service if you do not have health insurance.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance will be billed for you. You are responsible for any co-payment or deductible amounts as stated by Medicare and your secondary insurance company.

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. As a courtesy, we will bill your secondary insurance once. However, if you secondary insurance is unpaid the bill will be transferred to patient responsibility.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan. Prior to visit a specialist, you must have a referral authorized from your primary doctor (care physician). Unless your referral is presented at the time of the visit, you are financially responsible for the services received. You will be given the option to reschedule your appointment without cancellation fee. Otherwise without an authorized referral, payment is due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of that visit.

PATIENT BILLING: You will be sent three notices of your financial responsibility after payment and/or explanation of benefits (EOB) is received from insurance company. After the third notice your account may be forwarded to collections with Westcoast Adjusters. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: checks, cash, and/or Visa, MasterCard, American Express, and Discover cards. An additional $25.00 will be added to your statement if the check is returned for insufficient funds.

In the event that your insurance company should happen to send payment to you, the patient, we will expect that you will forward it to our office to be applied to your balance.

PRIVACY STATEMENT: Any information disclosed in your record 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.

ASSIGNMENT OF BENEFITS:

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to DR. GRABOWSKI PC all insurance benefits for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. 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 signature on all insurance submissions.

My signature confirms that I have read the above policy regarding my financial responsibility to DR. GRABOWSKI PC. I agree to pay DR. GRABOWSKI PC in full any balance incurred by me or my dependent in the event that there is no health insurance coverage. I understand that is my responsibility to inform the doctor's office if there is a change in my health insurance information.

FINANCIAL RESPONSIBILITY PARTY:

Patient: _____ _____ ____/____/____

Signature Print Name Date

Guarantor: _____ _____ ____/____/____

Signature Print Name Date