1275 Olentangy River Rd., Ste. 10
Columbus, Ohio 43212
Telephone (614) 291-5555
Fax: (614) 291-7720

Kaplansky
Foot and Ankle Centers
www.ColumbusOhioPodiatrist.com

7509 E. Main Street
Reynoldsburg, Ohio 43068
Telephone: (614) 868-5555
Fax: (614) 868-5561

Dr. David B. Kaplansky
Dr. Anthony Cozzolino
Dr. Isin Mustafa

#

DATE: _____/_____/_____

PATIENT INFORMATION:

PATIENT NAME: _____ **MIDDLE INITIAL:** _____ **LAST NAME:** _____

SEX: MALE OR FEMALE **DATE OF BIRTH:** _____ **AGE:** _____ **S.S. NO.:** _____

HOME ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PRIMARY PHONE NO.: (_____) _____-_____ **MAY WE LEAVE A MESSAGE?** ☐ YES ☐ NO

ALTERNATE PHONE NO.: (_____) _____-_____ **MAY WE LEAVE A MESSAGE?** ☐ YES ☐ NO

E-MAIL: _____ **MAY WE SEND YOU MESSAGES?** ☐ YES ☐ NO

PRIMARY LANGUAGE: _____ **ETHNICITY:** _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? ☐ YES ☐ NO

IF YES, NAME: _____ **PHONE NO.:** (_____) _____-_____

EMERGENCY CONTACT INFORMATION:

NAME: _____ RELATIONSHIP: _____ PHONE NO.: (_____) _____-_____

PRIMARY CARE DOCTOR:

NAME: _____ PHONE NO.: (_____) _____-_____

ADDRESS: _____

REFERRAL INFORMATION:

WHO REFERRED YOU TO OUR OFFICE?

☐ PATIENT/FRIEND ☐ PHONE BOOK ☐ INTERNET ☐ OTHER: _____

☐ DOCTOR. IF SO, PLEASE PROVIDE NAME & PHONE NO.: _____

PHARMACY INFORMATION:

NAME: _____ PHONE NO.: (_____) _____-_____

ADDRESS: _____

MEDICATION LIST: PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING **OR PROVIDE A COPY OF YOUR MEDICATION LIST**.

MEDICATION NAME	DOSAGE	MEDICATION NAME	DOSAGE

ALLERGIES

☐ NONE ☐ LATEX ☐ ADHESIVE TAPE ☐ IODINE ☐ SULFA ☐ PENICILLIN

☐ INSECTS ☐ OTHER: _____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED/PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO. PER WEEK: _____ ☐ QUIT. HOW LONG AGO? _____

USE OF TOBACCO: ☐ NEVER ☐ SMOKER ____ PACKS/DAY FOR ____ YEARS ☐ QUIT-HOW LONG AGO? _____

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ YES. DRUG? _____ ☐ QUIT-HOW LONG AGO? _____

EMPLOYMENT INFORMATION

STATUS: ☐ FULL-TIME ☐ PART-TIME ☐ DISABLED ☐ RETIRED ☐ SELF-EMPLOYED ☐ UNEMPLOYED

OCCUPATION: _____

PATIENT MEDICAL HISTORY: PLEASE INDICATE ALL THAT APPLY.

☐ AIDS/HIV
☐ ANEMIA OR BLEEDING DISORDER
☐ ARTHRITIS (RHEUMATOID OR OSTEOARTHRITIS)
☐ ASTHMA
☐ BACK PROBLEMS
☐ BRONCHIAL PROBLEMS
☐ CANCER
☐ CHEMICAL DEPENDENCY
☐ CHEST PAIN
☐ CHRONIC PAIN SYNDROME
☐ BLOOD CLOTS/DVT
☐ CIRCULATORY PROBLEMS
☐ DEPRESSION/ANXIETY
☐ DIABETES
☐ EMPHYSEMA
☐ EPILEPSY
☐ EYE PROBLEMS
☐ FAINTING
☐ FIBROMYALGIA
☐ FOOT AND/OR LEG CRAMPS
☐ GOUT
☐ HEART DISEASE/MURMUR/ANGINA
☐ HEPATITIS OR JAUNDICE
☐ HIGH BLOOD PRESSURE
☐ MRSA
☐ HIGH CHOLESTEROL
☐ HYPOTHYROIDISM
☐ KIDNEY OR BLADDER PROBLEMS
☐ LIVER DISEASE
☐ PHLEBITIS
☐ RADIATION THERAPY
☐ RESPIRATORY DISEASE
☐ SHORTNESS OF BREATH
☐ SPECIAL DIET
☐ STROKE
☐ SWELLING OF ANKLES OR FEET
☐ TUBERCULOSIS
☐ ULCERS
☐ OTHER _____

LAST FLU VACCINE: _____ **LAST PNEUMONIA VACCINE:** _____

FAMILY MEDICAL HISTORY: PLEASE INDICATE WHICH IMMEDIATE FAMILY MEMBER (MOTHER, FATHER, BROTHER AND/OR SISTER).

☐ DIABETES _____
☐ HEART DISEASE _____
☐ BLEEDING DISORDERS _____
☐ CANCER _____
☐ NEUROLOGICAL PROBLEMS _____
☐ OTHER _____

SURGERY HISTORY: PLEASE LIST ALL PRIOR SURGERIES.

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

VITAL SIGNS: HIGH BLOOD PRESSURE & PULSE WILL BE TAKEN BY MEDICAL ASSITANT.

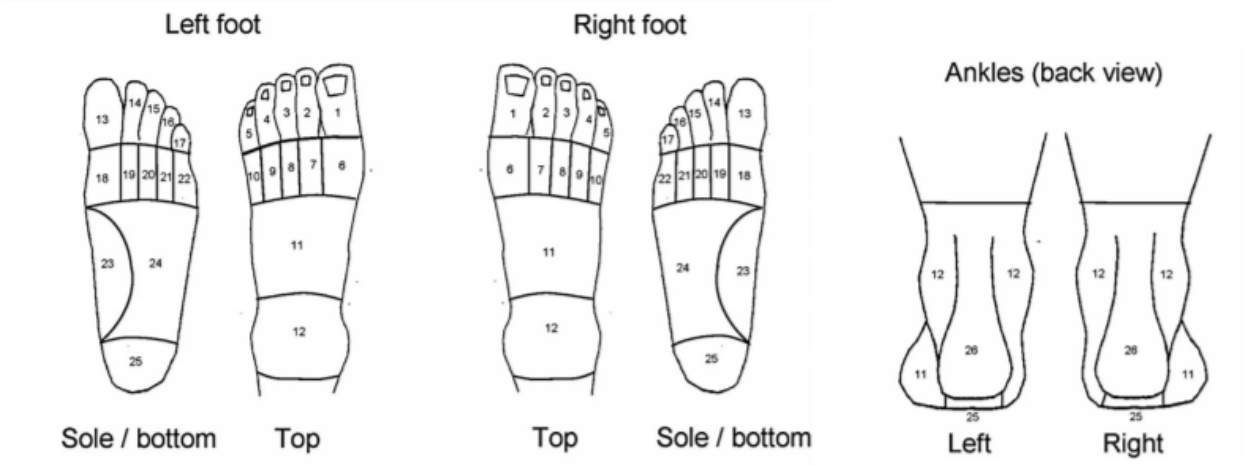
WEIGHT: _____ **HEIGHT**: _____ **BLOOD PRESSURE**: _____/_____ **PULSE**: _____ **SHOE SIZE**: _____

CURRENT PROBLEM (CHIEF COMPLAINT):

DESCRIBE THE FOOT OR ANKLE PROBLEM YOU ARE CURRENTLY HAVING?

_____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.



CHIEF COMPLAINT DETAILS:

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ ☐ DAYS ☐ WEEKS ☐ MONTHS ☐ YEARS

DID YOUR PAIN OR PROBLEM BEGIN: ☐ SUDDENLY ☐ GRADUALLY DEVELOPED OVER TIME

SINCE PROBLEM STARTED, HAS IT REMAINED? ☐ THE SAME ☐ BECAME WORSE ☐ IMPROVED

HOW WOULD YOU DESCRIBE YOUR PAIN?

☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ ITCHING ☐ BURNING ☐ RADIATING

☐ STABBING ☐ THROBBING ☐ OTHER: _____

IS PAIN? ☐ MILD ☐ MODERATE ☐ STRONG ☐ SEVERE

PAIN IS (WORSE) WHILE:

☐ WALKING ☐ STANDING ☐ RUNNING ☐ RESTING ☐ HIGH HEELS ☐ WITH PRESSURE ☐ FLAT SHOES

☐ WEARING CLOSED TOE SHOES ☐ WITH PRESSURE ☐ 1ST TIME AFTER GETTING UP IN THE AM ☐ AT NIGHT TIME ONLY

☐ AFTER SEATING FOR LONG PERIODS OF TIME ☐ OTHER: _____

HOW ARE YOU CURRENTLY TREATING THIS PROBLEM? _____

PERCENTAGE OF THE DAY YOU SPEND ON YOUR FEET: ☐ 0% ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

HAS ANY OTHER DOCTOR, URGENT CARE, OR HOSPITAL TREATED YOUR PROBLEM? ☐ YES ☐ NO
IF YES, PROVIDE NAME OF DOCTOR OR FACILITY? _____

HAVE YOU HAD IMAGING (X-RAYS OR MRI) DONE PREVIOUSLY?
IF YES, WHERE & WHEN: _____

IS THIS PROBLEM A WORK/CAR REALATED INJURY? ☐ YES. DATE OF INJURY: _____ ☐ NO
IF YES, PLEASE EXPLAIN IN DETAIL.
_____
_____
_____

***** DIABETIC PATIENTS ONLY *****

TYPE: ☐ I (ONE) ☐ II (TWO)
CONTROLLED WITH: ☐ INSULIN ☐ MEDICATIONS ☐ BOTH
BY DOCTOR: _____
☐ ENDO ☐ PCP ☐ PHARMACIST
LAST A1C: _____ **DATE:** _____
FBS: _____ **DATE:** _____

LAST EYE EXAM: _____
DO YOU SEE A NEPHROLOGIST (KIDNEY) DOCTOR?
_____
_____
DO YOU HAVE NEUROPATHY? ☐ YES ☐ NO
ARE YOU INTERESTED IN DIABETIC SHOES? ☐ YES ☐ NO

FINANCIAL POLICY FOR KAPLANSKY FOOT & ANKLE CENTERS

Kaplansky Foot and Ankle Centers, would like to thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

No Shows: There may be a Charge of $30.00 for all no show appointments.

INSURANCE: All co-payments and deductible must be paid at the time of service. We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider; however, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any co-payments, which are usually 20% of the allowed amount for an item or service.

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

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 payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan, which mandates us that when you visit a 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. 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 services received due in full upon completion of the visit.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. If we participate with your Insurance we will file Insurance before billing you. 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. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. 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: Cash, Check or VISA/MasterCard. 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 expect that you would forward it to our office to be applied to your balance.

***** THIS COPY IS TO BE KEPT BY PATIENT *****

FINANCIAL POLICY FOR KAPLANSKY FOOT & ANKLE CENTERS

I have read the above policy regarding my financial responsibility to Kaplansky Foot & Ankle Centers for medical services provided. I agree to pay Kaplansky Foot & Ankle Centers any balance unpaid by my insurance carrier for myself or the below named person.

Insurance Information

Primary Insurance Company Name: _____
I.D. No.: _____ Group No.: _____
Insured Name: _____ Date of Birth: _____

Secondary Insurance Company Name: _____
I.D. No.: _____ Group No.: _____
Insured Name: _____ Date of Birth: _____

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Kaplansky Foot & Ankle Centers all insurance benefits, payable to me 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 this signature on all insurance submissions.

PRINT Patient Name: _____

X**Signature:** _____

GUARANTOR/ FINANCIALLY RESPONSIBLE PARTY (**IF DIFFERENT** THAN ABOVE):

PRINT Name: _____

Guarantor Address_____City: _____

State: _____ Zip Code: _____ Guarantor Phone No. _____

Guarantor S.S. No. _____ Relationship to Patient: _____

Guarantor Signature: _____ Date: _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Uses and Disclosures of Health Information: We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for you services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization: Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization: In the following circumstances, we may disclose your health information without your written permission:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights: As our patients, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please ask for a copy of the Notice of Privacy Practices and the name of person or persons whom you may contact.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____

Patient/Parent/Authorized Representative Name (please print) Date

X _____

Signature

KAPLANSKY FOOT & ANKLE CENTERS

OFFICE POLICY

Appointments: If you are unable to keep an appointment, please call the office to reschedule at least 24 hours in advance. Patients who no show/no call three appointments may be asked to transfer their records to another doctor. Patients who are 15 minutes late to their scheduled appointment may be asked to reschedule their appointment to another date and time.

Kaplansky Foot and Ankle Centers reserves the right to terminate the doctor-patient relationship for the following reasons:

- Treatment non-adherence—The patient does not or will not follow the treatment plan.
- Follow-up non-adherence—The patient repeatedly cancels follow-up visits or is a no-show.
- Office policy non-adherence—The patient uses weekend on-call physicians or multiple healthcare practitioners to obtain refill prescriptions when office policy specifies a certain number of refills between visits.
- Verbal abuse—The patient or a family member is rude and uses improper language with office personnel, exhibits violent behavior, makes threats of physical harm, or uses anger to jeopardize the safety and well-being of office personnel with threats of violent actions.
- Nonpayment—The patient owes a backlog of bills and has declined to work with the office to establish a payment plan.

ACKNOWLEDGMENT OF RECEIPT OF OFFICE POLICY

I acknowledge that I was provided a copy of Office Policy and that I have read (or had the opportunity to read if I so chose) and understand the all policies.

_____ _____

Patient/Parent/Authorized Representative Name (please print) Date

X _____

Signature