Kaplansky
Foot and Ankle Centers

Columbus Office
1275 Olentangy River Rd Ste 10
Columbus, OH 43212
P: (614) 291-5555
F: (614) 291-7720

Dr. David Kaplansky
Dr. Anthony Cozzolino
columbusohiopodiatrist.com

Reynoldsburg Office
7509 East Main Street
Reynoldsburg, OH 43068
P: (614) 868-5555
F: (614) 868-5561

* REQUIRED FIELDS IN **BOLD** *

DATE: _____

IDENTIFICATION:

LEGAL FIRST NAME: _____ **MI:** ____ **LEGAL LAST NAME:** _____

FIRST NAME USED: _____ **LEGAL SEX:** **MALE / FEMALE** **(circle)**

SSN: _____ **D.O.B.:** _____

CONTACT:

ADDRESS: _____

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

MOBILE PHONE: _____ **CONSENT TO TEXT:** **YES / NO** **(circle)**

HOME PHONE: _____ WORK PHONE: _____

CONSENT TO AUTOMATED CALLS (appointments, results, etc): **YES / NO** **(circle)**

PATIENT EMAIL: _____

CONTACT PREFERENCE: **MOBILE # / HOME # / WORK # / EMAIL / PATIENT PORTAL*** **(circle)**

** **PATIENT PORTAL ACCESS** - appointments, medical records, billing and more **
EASY IN-OFFICE REGISTRATION - ask our team to get you started while you're here.

DEMOGRAPHICS:

LANGUAGE: _____ RACE: _____ ETHNICITY: _____

MARITAL STATUS: _____ GENDER IDENTITY: _____ PRONOUNS: _____

ADDITIONAL INFORMATION:

PATIENT CARE SUMMARY & LETTER DELIVERY PREFERENCE: **PATIENT PORTAL / PAPER** **(circle)**

HOW DID YOU HEAR ABOUT US? _____

EMPLOYMENT:

EMPLOYER NAME: _____ EMPLOYER PHONE: _____

USUAL OCCUPATION (CURRENT /MOST RECENT): _____

USUAL INDUSTRY (NOTE IF CURRENT STUDENT): _____

CARE TEAM:

PRIMARY CARE PROVIDER: _____ **PHONE:** _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

EMERGENCY CONTACT:

NAME: _____

RELATIONSHIP: _____

PHONE: _____

NEXT OF KIN:

NAME: _____

RELATIONSHIP: _____

PHONE: _____

GUARDIAN:

FIRST NAME: _____ MI: _____ LAST NAME: _____

GUARANTOR (NAME TO WHOM STATEMENTS ARE SENT):

RELATIONSHIP TO GUARANTOR (circle one) :

SELF / SPOUSE / CHILD / CHILD (MOTHER'S INS.) / CHILD (FATHER'S INS.) / OTHER (LIST BELOW)

***OTHER:** _____ **D.O.B.:** _____

FIRST NAME: _____ **MI:** _____ **LAST NAME:** _____

ADDRESS SAME AS PATIENT: YES / NO (circle) *IF NO, COMPLETE ADDRESS FIELDS BELOW

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ **MEMBER ID:** _____

POLICY HOLDER NAME: _____ **POLICY HOLDER D.O.B.:** _____

SECONDARY INSURANCE: _____ **MEMBER ID:** _____

POLICY HOLDER NAME: _____ **POLICY HOLDER D.O.B.:** _____

PHARMACY INFORMATION:

NAME / LOCATION: _____ **PHONE:** _____

MEDICATION LIST:

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

MEDICATION	DOSAGE	MEDICATION	DOSAGE

VACCINATIONS:

LAST FLU: _____ LAST PNEUMONIA: _____ LAST COVID-19: _____

ALLERGIES:

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

☐ OTHER: _____

FAMILY MEDICAL HISTORY:

PLEASE INDICATE **WHICH** IMMEDIATE FAMILY MEMBER (MOTHER, FATHER, BROTHER AND / OR SISTER)

☐ DIABETES _____ ☐ CANCER _____

☐ HEART DISEASE _____ ☐ NEUROLOGICAL PROBLEMS _____

☐ BLEEDING DISORDERS _____ ☐ OTHER _____

SOCIAL HISTORY:

USE OF TOBACCO/NICOTINE: ☐ NEVER ☐ SMOKER:____ PKS/DAY FOR ___YEARS ☐ QUIT: DATE: _____

USE OF ALCOHOL: ☐ NEVER ☐ YES, DRINKS / WEEK: _____ ☐ QUIT: DATE:_____

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ YES, DRUG: _____ ☐ QUIT: DATE:_____

USE OF CAFFEINE: ☐ NEVER ☐ YES, CUPS / DAY: _____

MEDICAL HISTORY:

PLEASE INDICATE ALL THAT APPLY

☐ AIDS / HIV
☐ ANEMIA OR BLEEDING DISORDER
☐ ARTHRITIS (RHEUMATOID OR OSTEOARTHRITIS)
☐ ARTIFICIAL JOINTS
☐ ASTHMA
☐ BACK PROBLEMS / PAIN
☐ BLOOD CLOTS / DVT
☐ CANCER
☐ CHEMICAL DEPENDENCY
☐ CHEST PAIN
☐ CHRONIC PAIN SYNDROME
☐ CIRCULATORY PROBLEMS / PVD
☐ CORONARY ARTERY DISEASE
☐ DEPRESSION / ANXIETY
☐ DIABETES
☐ EDEMA
☐ EPILEPSY / SEIZURES
☐ FAINTING
☐ FIBROMYALGIA
☐ FOOT DEFORMITY
☐ FOOT AND / OR LEG CRAMPS
☐ GOUT
☐ HEART DISEASE / MURMUR / ANGINA
☐ HEPATITIS OR JAUNDICE
☐ HIGH CHOLESTEROL / DYSLIPIDEMIA
☐ HYPERTENSION (HIGH BLOOD PRESSURE)
☐ HYPOTHYROIDISM
☐ KIDNEY DISEASE / DIALYSIS
☐ LIVER DISEASE
☐ MRSA
☐ ORGAN TRANSPLANT
☐ OSTEOPOROSIS
☐ PACEMAKER
☐ PHLEBITIS
☐ RADIATION THERAPY
☐ RAYNAUD'S DISEASE
☐ RESPIRATORY / LUNG DISEASE
☐ SPECIAL DIET
☐ STROKE
☐ SUBSTANCE ABUSE
☐ SWELLING OF ANKLES OR FEET
☐ TUBERCULOSIS
☐ ULCERS
☐ VARICOSE VEINS
☐ OTHER _____

SURGICAL HISTORY:

PLEASE LIST ALL PRIOR SURGERIES

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

VITAL SIGNS:

** BLOOD PRESSURE, PULSE & TEMPERATURE MAY BE TAKEN BY MEDICAL ASSISTANT **

WEIGHT: _____ HEIGHT: _____ BLOOD PRESSURE: _____/_____ PULSE: _____ TEMP.: _____

SHOE SIZE: _____ MISC. INFO: _____

NOTES: _____

_____

CURRENT PROBLEM (CHIEF COMPLAINT):

DESCRIBE THE FOOT OR ANKLE PROBLEM YOU ARE CURRENTLY EXPERIENCING: _____

_____

_____

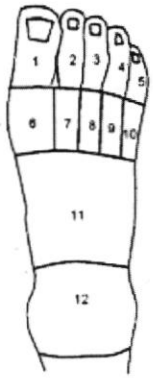
WHERE IS THE PAIN / PROBLEM LOCATED? (PLEASE MARK PICTURES BELOW)

Left foot

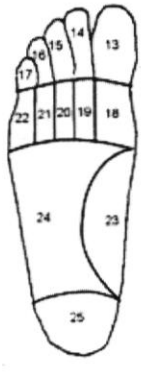
Sole / bottom

Top

Right foot

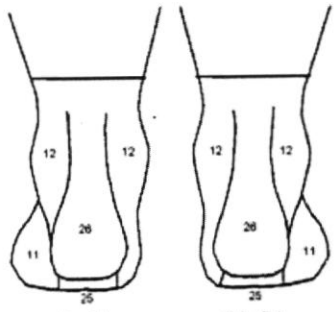


Top



Sole / bottom

Ankles (back view)



Left Right

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 ☐ BECOME 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 ☐ CLOSED TOE SHOES ☐ GETTING UP IN THE AM ☐ NIGHT TIME ONLY

☐ AFTER SITTING 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 / FACILITY: _____

HAVE YOU HAD IMAGING (X-RAYS / MRI) DONE PREVIOUSLY? ☐ YES ☐ NO

IF YES, WHERE & WHEN: _____

IS THIS PROBLEM A WORK / CAR RELATED INJURY? ☐ YES: DATE OF INJURY: _____ ☐ NO

IF YES, PLEASE EXPLAIN: _____

*** 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

NOTES: _____

_____

_____

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FINANCIAL POLICY

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 / co-insurance, 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.

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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 your 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.

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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.

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ASSIGNMENT OF BENEFITS, ACKNOWLEDGEMENT AND AUTHORIZATION

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.

I acknowledge that I was provided a copy of the Assignment of Benefits (above) and that I have read (or had the opportunity to read if I so chose) and understand the policy.

Signed: _____ Date: _____

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

Signed: _____ Date: _____

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

Signed: _____ Date: _____

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

Signed: _____ Date: _____

PRINT Patient/Parent/Authorized Representative Name: _____

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Dr. Anthony Cozzolino
Podiatrists

7509 E. Main Street
Reynoldsburg, Ohio 43068
Telephone: (614) 868-5555
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Consent Form for Photography, Videography and Media Usage

Patient Name: _____ DOB: _____

As part of your care at Kaplansky Foot and Ankle Centers, photographs and/or videos may be obtained during your consultation, treatment or procedure. These images may serve the following purposes:

1. **Medical Records:** Images will be stored in your medical records for reference and documentation of your treatment.

2. **Educational Use:** Images may be used for educational purposes, including presentations to medical professionals, residents and students.

3. **Social media and Marketing:** Images may be used for educational posts, marketing or social media content to help inform and educate the public about podiatric care.

Confidentiality:

Any identifying information (e.g., face, name) will be excluded or blurred unless explicitly agreed upon.

Images will be treated with the utmost respect for your privacy and used responsibly.

Consent:

By signing below, I confirm that I have read and understood the above information. I voluntarily consent to the use of photographs and/or videos as described. I understand that I may revoke this consent at any time by submitting a written request, except for images already used and/or published.

___**I DO** consent to the use of my photographs/videos for the purposes outline above.

___**I DO NOT** consent to the use of my photographs/videos beyond placement in my medical records.

Signature of Patient or Guardian:_____ Date:_____