Associated Podiatrists, P.C.
26750 Providence Parkway
Suite 130 - Novi, MI 48374
Telephone: (248)348-5300

PLEASE FILL OUT COMPLETELY Today's date _____

Name (First, Middle, Last):_____ DOB: _____

Home Address: _____

City_____ State _____ Zip _____ SS# _____-_____-_____

Primary Number: _____ please specify: ☐ Home ☐ Cell ☐ Other

Secondary Number: _____ please specify: ☐ Home ☐ Cell ☐ Other

Employer: _____ Work Number: _____

Circle One: Male Female Circle One: Married Divorced Widowed Single

Email Address: _____

Primary Insurance: _____ Subscriber's DOB/Relationship: _____

Secondary Insurance: _____ Subscriber's DOB/Relationship: _____

Pharmacy Name: Address (list crossroads if known) _____

Pharmacy Phone Number: _____ City: _____

Emergency Contact (Please list name, relationship and contact number)

1) _____

2) _____

General Health (Circle): Excellent Good Fair Poor

Primary Care Physician's Name, Address, Phone: _____

_____

Previous Podiatric History_____

Previous Surgical History_____

Height _____ Weight_____ Shoe Size _____

Are You Allergic to Any of the Following?

Penicillin: Yes____ No____ Codeine: Yes ____ No____ Local Injections/Anesthetics: Yes____ No____

Any other Drug Allergies? If so, please list: _____

I consent to allow Associated Podiatrists, P.C. to pull my pharmacy and drug utilization history for purposes of my medical treatment.

Signature: _____

Do you have or have you ever had any of the following? **Please answer both columns with a YES or NO.**

Yes	No	Hepatitis (What Type?) _____	Yes	No	HIV Positive/AIDS
Yes	No	Chest Pains	Yes	No	Persistent Cough
Yes	No	Heart Murmur	Yes	No	Genetic Problems
Yes	No	Ulcers	Yes	No	Sexually Transmitted Disease
Yes	No	Anemia	Yes	No	Gonorrhea, Syphilis
Yes	No	Stroke	Yes	No	Genital Herpes
Yes	No	Hormonal Problems	Yes	No	Epilepsy, Seizures
Yes	No	Problems with bruising easily	Yes	No	Sinus Trouble
Yes	No	Tuberculosis, Lung Disease	Yes	No	Neurologic Disorders
Yes	No	Excessive Urination and/or Thirst	Yes	No	Skin Disease
Yes	No	Prolonged Bleeding Problems	Yes	No	Cancer (Form) _____
Yes	No	Sickle Cell Anemia	Yes	No	Unexplained Fevers
Yes	No	Prosthetic Valves/Joints	Yes	No	Enlarged Lymph Nodes
Yes	No	Jaundice (Liver Disease)	Yes	No	Persistent Diarrhea
Yes	No	Allergies/Hives	Yes	No	Arthritis
Yes	No	Rheumatic Fever	Yes	No	Pacemaker
Yes	No	Kidney Problems (Please List) _____	Yes	No	Blood Transfusion
Yes	No	Diabetes	Yes	No	Chronic Transfusions
Yes	No	Glaucoma	Yes	No	Prolonged Sore Throat
Yes	No	Psychiatric Problems (Please List): _____	Yes	No	Night Sweats
			Yes	No	Bluish-Reddish Lesions

Yes No Heart Problems (Disease, Surgery, Attack, Congenital Heart Defects)
Yes No Allergy or sensitivity to any metals?
Yes No History of cold sores, fever blisters, or canker sores?
Yes No Are you being treated with immunosuppressive drugs? (Please List) _____
How many glasses of alcohol do you consume a week? _____

Yes No Have you ever used drugs for recreational purposes? _____

Yes No Do you have any pierced body parts? (Please List) _____

Yes No Postural Hypotension (fainting spells)
Yes No Abnormal Blood Pressure (HIGH LOW)
Yes No Have you ever been informed that you must be pre-medicated for surgery?
Yes No Do you have any disease, condition or problem not listed? (Please List) _____

_____

Use of Tobacco: ☐ Never ☐ Quit – How long ago? _____ ☐ Smoke _____ Packs/Day for _____ Years

How did you hear about us? ☐ Referred by PCP ☐ Internet ☐ Advertising _____

☐ Family or Friend _____ ☐ Other _____

Present Complaint: _____

I hereby give permission to an Associated Podiatrists, P.C. Podiatrist and Assistants as may participate with my treatment to examine and treat my feet medically, surgically, or orthopedically, and release information to my physicians and/or insurance companies.

Signature: _____ Date: _____

MEDICATION RECORD & FAMILY MEDICAL HISTORY

Please list ALL medications you are currently taking or present staff with a copy of your med list:

Date	Medication	Dosage	Frequency

Date of last pneumonia vaccine: _____

Family Medical History

Use the list of diseases below and any other significant history to fill in the appropriate boxes:

ALCOHOLISM	ANEURYSM	ARTHRITIS _____	GLAUCOMA	S
BUNIONS	CANCER (Type) _____	DIABETES	OSTEOPOROSIS	
CONNECTIVE TISSUE DX	HEART DISEASE	HIGH BLOOD PRESSURE	PSYCHIATRIC DX	
THYROID DISORDER	TUBERCULOSIS	SEIZURES	HIGH CHOLESTEROL	

FAMILY MEMBER	HEALTH PROBLEMS	AGE OF ONSET	CAUSE OF DEATH, IF DECEASED
Mother			
Father			
Brother			
Sister			
Maternal Grandmother			
Paternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Aunt			
Uncle			
Other_____			

Financial Policy for Associated Podiatrists, P.C.

Thank you for choosing Associated Podiatrists, P.C. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Because of the extremely large volume of patients we see, it is impossible for our office to check your policy. We ask that you take on the responsibility of checking your own health insurance contract. **It is important to know that YOU are responsible to understand the terms of your own policy, not the doctor.**

2. About Co-payments and deductibles. All co-pays and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. If you have not met your deductible you will be billed for the approved insurance amount.

3. Non-covered services. Please be aware that some, and perhaps all, of the services you receive may be not covered or not considered reasonable or necessary by your insurance. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. 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. Your insurance benefit is a contract between **YOU** and your insurance company.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8: Referrals. If you are enrolled in an HMO, which requires a referral from your Primary Care Physician, you must have a referral with you in order to be seen by the physician. If you arrive with no referral, you have two options: you can reschedule, or you may pay for the visit and procedures at the time of service.

9. About Procedures requiring the use of Laboratories (ie: Blood work, biopsies, cultures): It is your responsibility to inform us if a specific laboratory is required. If we send the laboratory work to the wrong lab we may bill you. Our primary laboratory is Quest Diagnostics Laboratory. We appreciate your assistance in working with our staff.

Insurance Authorization and Assignment

Professional services rendered by Associated Podiatrists, P.C. are the ultimate responsibility of the patient (and/or guardian). Associated Podiatrists, P. C. will assist in facilitating reimbursement from third party carriers by verifying coverage when necessary. However, by verifying coverage, the extent of that coverage is not a guarantee for payment of the rendered treatment. Therefore, any uncovered or unpaid service is the complete responsibility of the patient (and/or guardian) to pay Associated Podiatrists, P.C. in a timely and acceptable time frame.

I hereby authorize Associated Podiatrists, P.C. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance and any co-pays delineated by my policy.

Acknowledgement of Receipt of Privacy Practices

I acknowledge that a copy of the Notice of Privacy Practices will be made available to me at my request, and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Signature (Parent if a minor): _____ Date: _____

Associated Podiatrists, P.C.

Dr. Marc A. Borovoy, Dr. John D. Miller

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:

- ☐ Myself only
- ☐ My spouse or significant other (specify name) _____
- ☐ My parent(s) (specify name) _____
- ☐ Other (specify name & relation) _____

Information to be disclosed: ☐ All information

- ☐ Laboratory results ☐ X-Ray results/films
- ☐ Diagnosis ☐ Medications
- ☐ Other _____ ☐ Dates of Service _____

I would like to be contacted at my:

- ☐ Home Phone _____ ☐ Work Phone _____
- ☐ Cell Phone _____ ☐ Email _____

Please check the box below regarding the office staff or physician leaving information or confirming appointments on my answering machine, voice mail or with my answering service:

- ☐ No, I do not want any information left on my answering system.
- ☐ Yes, I give my permission for only non-medical messages and appointment reminders to be left on my answering system.
- ☐ Yes, I give my permission for medical information, non-medical messages and appointment reminders to be left on my message system.

This authorization shall be in force and effective until revoked, at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at the below address. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal HIPAA Privacy Rule or state law.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Description of Personal Representative