MICHFOOT SURGEONS P.C.

Welcome to our office

Patient Name_____

Address_____

City_____Zip_____

Home Phone_____ Cell_____

Email address_____

How is it best for us to confirm appointments? ☐ Email ☐ Text ☐ Call

Emergency contact name and phone_____

Your date of birth_____

What type of work do you do?_____

How were you referred to this office?_____

Name of primary care physician_____City_____

Pharmacy Name and Location (cross streets/ zip code)

_____

I give my permission for Fred B. Leff DPM/ Randy M. Leff DPM/ Kevin C. Sorensen DPM/Kristina E. Green, DPM to treat my foot condition. I authorize any and all medical insurances to send payment for services directly to Michfoot Surgeons P.C. **I acknowledge that I am responsible for knowing my insurance plan and all inclusions or exclusions in coverage. As such, I understand that I may be responsible for out of pocket expenses that must be paid in a timely manner.** Failure to do so may result in cessation of services and my account being turned over to a collection agency.

_____

Signature of Patient

_____

Signature of Parent/Guardian if Patient is a Minor

Date: _____

Michfoot Surgeons PC
29275 Northwestern Hwy. Suite 207 Southfield, MI 48034
248-355-4000 248-355-4047 (f) www.michfoot.com

Michfoot Surgeons PC History and Physical Form

Date:

Name: Age: Height: Weight: Shoe Size:

Chief Complaint:

Please Describe the Symptoms:

Duration of the problem:

Previous or home treatments:

Other Foot Problems:

Bunions ☐ Hammertoes ☐ Heel/Arch pain ☐ Corns/Callouses ☐ Poor Circulation ☐ Ingrown Nails ☐

Flat Feet ☐ Warts ☐ Ankle pain ☐ Arthritis/Stiffness ☐ Neuroma ☐ Fungal Nails ☐

Other:

Past Medical History: Are you or have you been treated for any of the following conditions? Circle all that Apply to you.

Diabetes	Sickle Cell Anemia/Trait	High Cholesterol	Arthritis
High Blood Pressure	Heart Disease	Seizures	Gout
Stroke	HIV or Hepatitis	Bleeding Disorder	Stomach Ulcers
Asthma	Neuropathy	Blood Clots	Cancer:_____
Other Medical Problems:			

Family Medical History: Are or were any blood relatives treated for any of the following conditions? Circle all that Apply to your family.

Diabetes	Amputations	High Blood Pressure
Poor Circulation	Neuropathy	Heart Disease
Ulcerations	Bleeding Disorder	Bunions/Corns/Callouses
Other Medical/Foot Problems:		

Medications: Please list all medications that you currently take.

Past Surgical History: Please list any surgeries you have had both foot/ankle and body.

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Allergies: Please provide any medication allergies, circle the boxes that apply to you. None

Latex	Tylenol	Aspirin	Novocaine/Lidocaine	Iodine
Penicillin	Codeine	Motrin	Cortisone	Shell Fish
Sulfa	Tape	Darvon	Demerol	Keflex
Other allergies:				

Social History: Please circle and answer the following questions.

Do you smoke? Yes or No
If yes, how many packs per day? ____

Do you drink alcohol? Yes or No
If yes, how many drinks a week?____

Do you or have you used illicit drugs? Yes or No
If yes, what kind and how often?_____

Are you or could you be pregnant? Yes or No

What types of shoes do you normally wear?_____

Review of Systems: Please circle any problems you are experiencing

Constitutional:

decreased appetite	headache	weakness
weight loss	feeling the room spinning	weight gain
faintness	fever	dizziness
difficulty breathing when lying flat		

Cardiovascular:

chest or arm pain	cramps in legs or feet	varicose veins
heart palpitations	low blood pressure	heart murmur
cramps in legs/feet when sleeping	mitral valve prolapse	heart attack

Musculoskeletal:

joint aches or pain	stiffness	chronic low back pain
chronic ankle pain	swelling of joints	pain in feet in morning
weakness	chronic hip pain	limited motion in joints
chronic neck pain	morning stiffness	

Integument:

allergy to chemicals	thick or discolored toenails	cracked skin
skin cancer	scarring	itching skin
skin rash	pain associated with the skin	

Neurological:

tingling	pins and needles	shooting pain
burning	decreased sensation to touch	
radiating pain	decreased sensation to heat or cold	

Endocrine:

increase or decrease in thirst	diabetes mellitus	post menopause
weight loss or gain	thyroid problems	osteoporosis
increase or decrease in appetite	increase or decrease in urination	

Financial Policy

Thank you for choosing our office as part of your health care team. In our effort to provide personalized care in the most efficient and economical manner possible, we are providing to all of our patients this copy of our Financial Policy. We ask that you take a few moments to read our Financial Policy and sign below.

Insurance Coverage

- Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card.

- New insurance companies are continually forming and existing insurance companies are rapidly changing. It is your responsibility to know the specifics of your policy (referral requirements, in and out of network physicians and facilities, etc.). Most private insurance policies (non Medicare/Medicaid) plans now have deductibles, copayments, coinsurances, maximums and limitations (out of pocket expenses). If your annual out of pocket expenses have not been met, you will be required to pay a deposit at the time of your visit. This will be applied to your account and a statement will be sent reflecting any additional monies owed following response from your insurance carrier. If it has been stated by your carrier that a deductible deposit cannot be collected at the time of service, a valid credit card will be required and stored securely. Upon claim response, your credit card will be charged and a detailed statement will be provided along with a paid receipt.

- We rely on you to inform us of all insurances in effect and to notify the office immediately of any changes with your insurance. If you do not inform us of changes, you will be responsible for the services rendered. When multiple policies exist, it is the patient's responsibility to inform us which policy is the primary plan. If we are not provided ALL insurance information at the time of service, you will be responsible for paying Michfoot Surgeons PC directly and then submitting for reimbursement from your insurance company.

- All charges are the responsibility of the patient. We will bill your insurance company, but any services not covered are the patient's responsibility. If you have no insurance,

you are responsible for all services rendered. Co-pays will be collected at the time of the appointment (as required by insurance companies). For new patients, we will make every attempt to contact your insurance company to determine your office visit copayment, if any. Existing patients should notify us of any changes related to copayment amount right away.

- Costs can vary, depending on the type of insurance coverage you have and the treatment for your particular condition(s.) Cost/payment by your insurance company cannot be guaranteed by our staff. If you have any concerns, we advise you to contact your insurance company.
- If you miss an appointment, or cancel an appointment less than 24 hours of the appointment time, you may be assessed a fee, as we have reserved that time slot just for you. Missed appointment fees are the responsibility of the patient.
- If balances are not received within 30 days a stored credit card will be used to process payment. Past due accounts, more than 90 days, will be turned over to our collection agency.
- We reserve the right to charge a fee for completion of disability forms/other packets of requested documentation

Patient Name:_____

Patient Signature:_____

Date:_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

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