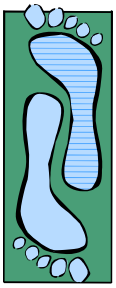

Welcome to Parkview Podiatry

Alanna L. Wargula, DPM and Adelina Stateva, DPM

Please have your insurance cards available and complete these forms in their entirety.

Patient Information

Patient Name: _____Gender: [ ] Male [ ] Female SS#_____/_____/_____

Date of Birth: _____/_____/_____ Address: _____

Parent's Name: _____DOB:___/___/___ SS# _____/_____/_____

Home Phone: _____ Parent's Work Phone: _____Cell Phone: _____

Primary Care Physician: _____ Referred By: _____

Insurance Information

Primary Insurance: _____ Insured's Name: _____

ID# or SS#: _____ Group#: _____

Secondary Insurance: _____ Insured's Name: _____

ID# or SS#: _____ Group#: _____

Name of Responsible Party: _____

Signature of Responsible Party: _____ Date: _____

Patient Medical History

Patient Name: _____Height:_____Weight:_____

Medical Allergies: _____

Medications (Please print names from your medicine bottles):_____

_____

Does the child have or has he/she ever been treated for any of the following?:

[ ] Diabetes	[ ] High Blood Pressure	[ ] Liver Disease	[ ] Heart Disease or Attack
[ ] Stroke	[ ] Cancer _____	[ ] High Cholesterol	[ ] Stomach Ulcer
[ ] HIV/AIDS	[ ] Hepatitis Type _____	[ ] Reflux	[ ] Asthma
[ ] COPD	[ ] Osteoporosis	[ ] Kidney Disease	[ ] Seizures
[ ] Arthritis	[ ] Rheumatoid Arthritis	[ ] Thyroid (Hyper/Hypo)	[ ] Parkinson 's disease
[ ] Psoriasis	[ ] Multiple Sclerosis	[ ] Fibromyalgia	[ ] Gout
[ ] Depression	[ ] Anxiety	[ ] Blood Clots	[ ] Psychiatric Disorder _____
[ ] Emphysema	[ ] Circulation Problems	[ ] Lupus	[ ] Mitral Valve Prolapse
[ ] Neuropathy	[ ] Pacemaker	[ ] Pain Syndrome	[ ] Pneumonia
[ ] Reynaud's	[ ] Sickle Cell Anemia	[ ] Skin Disorder	[ ] Sleep Apnea
[ ] Tuberculosis	[ ] Other: _____		

Surgical History

Please list any surgeries the child has had:

_____

_____

Family History

Does your family have a history of any of the following?

[ ] Diabetes	[ ] Cancer _____	[ ] Coronary Artery Disease
[ ] Heart Disease	[ ] High Blood Pressure	[ ] Stroke [ ] Thyroid Disease
[ ] Rheumatoid Arthritis	[ ] Blood Clots	[ ] Other: _____

Immunizations: Is your child up to date on immunizations? Yes _____ No, which ones? _____

Patient/Guardian Signature: _____ Date: _____

History of Current Foot/Ankle Problem Name: _____

Did the problem result from a specific injury? [ ] No [ ] Yes Please describe: _____

_____

Where is your pain located? [ ] Toe [ ] Heel [ ] Ankle [ ] Ball of foot [ ] Arch [ ] Left [ ] Right [ ] Both [ ] Other:

_____

_____

What is your complaint? _____

_____

How long have you had this complaint/condition? _____

_____

Please rate your pain on a scale of 1-10 (10 being the most painful):

At rest: 1 2 3 4 5 6 7 8 9 10 At its worst: 1 2 3 4 5 6 7 8 9 10

Is the pain: [ ] Constant [ ] Occasional [ ] Sharp [ ] Dull [ ] Aching [ ] Stabbing [ ] Throbbing [ ] Radiating/Traveling

Other: _____

What symptoms are you experiencing?

[ ] Locking [ ] Numbness [ ] Giving Away [ ] Popping [ ] Tingling [ ] Burning [ ] Grinding [ ] Swelling [ ] Bruising

Other: _____

Does anything make your symptoms feel better? _____

Does anything make your symptoms feel worse? _____

Have you seen another physician for this problem? _____

What treatments have you tried? [ ] Nothing [ ] Physical therapy [ ] injections [ ] Bracing [ ] Icing [ ] Compression

[ ] Medications [ ] Shoe change [ ] Arch support [ ] Massage [ ] Other_____

Have you had any of the following tests/studies?

Tests	Date	Facility
X-rays		
MRI/CT Scan		
Nerve Study		
Blood Tests		
Other:		

Signature: _____ Date: _____

Parkview Podiatry Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- There is a $25 fee for cancelations without 24 hour notice and missed appointments, your insurance does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT,
CONSENT TO PHOTOGRAPH, VIDEO AND/OR OBTAIN DIGITAL IMAGES,
And CONSENT TO SEND PRESCRIPTIONS ELECTRONICALLY

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given an opportunity to read the Notice of Privacy Practices, which is kept in the patient lobby and contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Parkview Podiatry will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in the policy of Dr. Wargula and Stateva. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I give permission to Parkview Podiatry to contact me by phone and it is ok to leave detailed message related to my medical condition.

I authorize Parkview Podiatry to discuss my medical history with the following people:

[ ] spouse
[ ] children: _____
[ ] other: _____

I agree that Parkview Podiatry may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes and consent to the use of electronic prescribing as federally mandated.

_____
Responsible Party's Signature Date