Henry K. Stark, DPM
701 Park Avenue
Lake Park, FL 33403
(561) 284-6886 / Fax: (561) 627-2199

Name_____ Date_____
Address_____ City_____
State_____ Zip_____ Marital Status_____
Telephone_____ Cell_____
SS# _____ Male_____ Female_____
Email_____ Employer_____
Spouse_____ Cell _____
Family Doctor_____ City_____
Last Seen_____ Pharmacy_____ City_____
Primary Insurance_____ Number_____
Policy Holder_____ **Date of Birth**_____
2nd. Insurance_____ Number_____
Policy Holder_____ Date of Birth_____
Referred by_____
Reason for Visit_____
Injury? Y / N When did this occur or start_____
Previous Treatments_____
Doctor(s)_____
Foot, Ankle or Leg Surgeries or tests**?**_____
_____

Privacy Information

Can we leave messages at any the above listed numbers? Home: Yes/No Work: Yes/No Cell: Yes/No
Emergency Contact Name: Relationship: Phone:_____
Names of family/friends who can pick up your records and/ medical supplies:
Names of family/friends who have parents' authorization to bring in the Minor child when guardian is absent:

Consent

I certify that the above and attached information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary to the diagnosis and/or treatment of me or my child's condition. As a representative of myself or as a guardian, I give authorization for the above listed patient to receive medical And/or surgical care and treatment with any of the doctors at Lake Park Podiatry.

Printed Patient's Name: Signature: Date:

Please fill out the information below to the best of your ability - Circle all that apply:

Allergies: None Adhesive Tape Aspirin Codeine Demerol Iodine Local Anesthetics Seafood Sulfa Drugs Penicillin

Other_____

Surgeries: None Eyes Ears Nose Throat Abdominal Legs Ankles Feet Toes Fractures

General History:

Weight**:** _____ Height**:** _____ Shoe Size: _____

Would you say your health is: Good / Fair / Poor ANY reason you MIGHT be pregnant? Yes / No

Smoking: Packs/day: _____ Years: _____ Past Smokers: Packs/days: _____ Years**:** _____

Caffeine: Quantity**:** _____ Alcohol: None Rarely Moderately Daily Quit

Recreational Drug Use: None Moderate Daily Quit

List Athletic activities: _____ Amount per day/week:_____

Employment requires you to: (circle which apply) Sit Stand Walk

Have you ever seen a podiatrist before: Yes / No

Please list**:** _____ Last Seen: _____

Have you ever worn orthotics/arch supports? Yes / No. If yes, what kind**:** _____

How did you hear about us**?** _____

Past Medical History: Do you have or ever had the following: (circle to indicate YES)

AIDS/HIV	Bunions	Fibromyalgia	Low Blood Pressure	Special Diet
Anemia	Cancer	Flat Feet	Lung Disease	Sports Related Injuries
Angina	Chest Pain	Gout	Nervous Problems	Stomach Ulcers
Ankle Pain	Chemical Dependency	Headaches	Osteoporosis	Stroke
Arthritis	Circulatory Problems	Heart Disease	Phlebitis	Swelling in ankles/feet
Artificial Heart Valves	Corns and Calluses	Heel Pain	Plantar Warts	Tired Feet
Artificial Joints Location:_____		Depression	Hemophilia	Radiation Treatment
Asthma	Diabetes (Type I or II)	High Blood Pressure	Rash	Thyroid Disease
Athlete's Foot	Ear Problems	Ingrown Toenails	Rheumatic Fever	Tuberculosis
Back Problems	Eye Problems	Kidney Problems	Seizure Disorders	Varicose Veins
Bleeding Disorders	Fainting	Liver Disease	Sinus Problems	Unexplained Weight Loss

Any other unlisted problems_____

Sensation History: Night Pain Burning Tingling Swelling Pain Cramps Numbness Feet Legs Calf

Medications: _____

_____

_____

_____

Please thoroughly read each of the Lake Park Podiatry policies:

We are dedicated to providing the best possible care to you and regard your complete understanding of our policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or Dr. Stark. Suggestions or grievances can be directed to the doctor via telephone, letter or email.

Treatment Agreement

I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

Release of Information

For the purpose of payment, I allow **Lake Park Podiatry** to release my Private Health Information to any and all my insurance carriers, their third payers and claim reviewers, until the claim is resolved. For the purpose of treatment, I also allow the above listed practice to release my information or contact any and all my treating physicians. I promise to provide complete and accurate information to the doctors about my health and medications, including over the counter products. I also understand my responsibility to be respectful of the doctors, staff and other patients.

Acknowledge of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the HIPPA Notice of Privacy Practices and that I have read (or had the opportunity to read if I chose so) and understand the Notice. The HIPPA rights are also posted in the lobby.

Patient Financial Policy

I must provide personal (address, phone numbers, etc.) and/or insurance changes (carriers, networks, id numbers, etc.) to the office prior to your appointment. I am responsible for **all authorizations/referrals / precertifications** needed to seek treatment with Lake Park Podiatry's physicians. My portion of payment for ALL office services is due at the time of service. We will accept credit cards, 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. When you do an assignment of benefits, you are agreeing to have your insurance company pay your doctor directly. If your insurance company does not pay the practice within 60 days, the patient or guardian seeking care for minor, will be responsible for payment of services. You are encouraged to contact your designated patient account representative at our office with any questions. Please honor our 24 hours reschedule notice, as there may be a charge for appointments broken or cancelled without 24 hours advanced notice. Repetitive broken or cancelled appointments and/or non-compliance may result in transfer of your care to an alternative practice. We have made prior arrangements with insurers and other health plans to accept assignment of benefits. We will bill those plans with which we have an agreement **and will require you to pay the co-pay/co-insurance/deductible at the time of service.** If you are seeing our doctors on an "Out of Network" basis, you will be subject to out of network rates. Not all services are a "covered" benefit in all insurance policies; some plans even impose a waiting period before covering services. In the event your health plan determines a service to be "not covered/pre-existing," or you do not have an authorization, you will be responsible for all charges. We will attempt to verify benefits for some specialized: 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.** Our office does not file secondary insurance, unless the patient has Medicare. For all other insurances, we will provide an itemized statement upon your request. If you possess two insurance plans, you **MUST notify us of your designated Primary Policy**. PAST DUE accounts are subject to collection proceedings including the credit bureau. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance of the office. Accounts no longer maintaining a financial "Good Faith" status will result in the termination of the **Lake Park Podiatry** relationship. There is a service fee of $30.00 for all returned checks. ONLY UNWORN and NON-custom items are returnable within 5 days of receipt. Custom items such as orthotics are non-refundable.

Authorization of Payment

I hereby assign all Medical benefits directly to **Lake Park Podiatry** for the payment of any services rendered. I also authorize release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay for the services I received, I will be financially responsible for payment.

Patients Name _____

Signature of Patient/Guardian: _____ Date: _____

Office Witness: _____ Date: _____ _____ Patient initials to indicate copy received

My signature authorizes the assignment of benefits to Lake Park Podiatry remain on file until further written notification.