**Dr. Kostadinka H. Skandeva, DPM DATE OF APPOINTMENT OR UPDATE  *\_\_\_\_\_\_\_\_\_\_\_***

**PATIENT INFORMATION (please print, fill out all sections completely – all sections are required)**

**LEGAL NAME (First)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(Last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(M.I.)\_\_\_\_\_\_\_\_**

**\_\_\_Female** \_\_\_ **Male \_\_\_\_** **Married** \_\_\_ **Single** \_\_\_ **Divorced** \_\_\_ **Widowed** \_\_\_ **Child (under 18) NICKNAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BIRTHDATE\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ SS#\_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ PHONE: (**\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_ (Main Number)

 **(**\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_ (Alternate)

 **(**\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_ (Work)

**MAILING ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_ ZIP\_\_\_\_\_\_\_**

**EMAIL ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYER (School, if student**) *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  **\_\_**\_ **Retired**

**FAMILY DR. (Name, Address and Phone Number ):**

**(MEDICARE PATIENTS: \*EXACT\* DATE OF LAST VISIT**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**FAMILY CONTACT INFORMATION:** \_\_\_ Spouse \_\_\_ Parent/Guardian \_\_\_ Other (specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**City** \_\_\_\_\_\_\_\_\_\_\_ **State/ZIP\_\_\_**

**Phone** (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_

**Employer** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone** (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

**Name & Phone # of closest person not living with you to contact in case of emergency:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**Payment Information**

**\*Please COMPLETE ALL information below and hand your insurance card to the receptionist. Our billing company requires both to properly submit your claim for payment.**

**Primary Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of policyholder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policyholder’s SS # \_\_\_\_\_\_\_\_\_\_\_\_\_ Policyholder’s Birth date\_\_\_\_\_\_\_\_**

**Relationship to policyholder**: \_ Self \_ Spouse \_ Child \_ other (please specify :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Secondary Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of policyholder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policyholder’s SS # \_\_\_\_\_\_\_\_\_\_\_\_\_ Policyholder’s Birth date\_\_\_\_\_\_\_\_**

**Relationship to policyholder**: \_ Self \_ Spouse \_ Child \_ Other (please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**How did you hear about us? Provide name, address and phone so we may send a thank you!**

**Doctor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospital**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Plan**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Internet**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ZocDoc**:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Friend:** (Name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_

**Is this person a patient here?** Yes/ No

**Other** (Please Specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY AND PHYSICAL**

CHIEF COMPLAINT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Onset date when condition started or injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location: Right, Left, Bilateral Foot or Ankle:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you suffered with pain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information Must Be Provided**:

Height:\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_ Shoe Size: \_\_\_\_\_\_\_\_\_\_\_ Shoe Width: \_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

\_\_\_Diabetes \_\_\_Hypertension \_\_\_Nervous Condition \_\_\_Stroke

\_\_\_Hypotension \_\_\_Hyperthyroidism \_\_\_Seizure Disorder \_\_\_Bleeding Disorder

\_\_\_Heart Disease \_\_\_Rheumatic Fever \_\_\_Skin problems \_\_\_Sickle Cell Anemia

Other Health Problems Not listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Surgical History in the Last Five Years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please List all Medication you are taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies to Medications:**

\_\_\_Penicillin \_\_\_Cephalosporin \_\_\_Sulfa \_\_\_Xylocaine/Lidocaine

\_\_\_Iodine \_\_\_Latex Gloves \_\_\_Tape \_\_\_Tetanus

\_\_\_Aspirin \_\_\_Codeine \_\_\_Sulfites

Please list all other Allergies not listed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History:

\_\_\_Diabetes \_\_\_Hypertension \_\_\_Heart Problems \_\_\_Circulatory \_\_\_Bleeding

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you smoke?** YES NO **Drink Coffee?** YES NO **Drink Alcohol?** YES NO OCCASIONALLY

**Financial Policy**

Thank you for choosing our practice! We are committed to providing you with quality podiatric care. We have

developed this payment policy to assist you in understanding our financial practices. Please read it carefully and

sign in the space provided.

**Insurance**

We participate with many insurance plans, including Medicare and Medicaid. If you are not insured by a plan we do business with or you do not have insurance, payment in full is expected at each visit. Your insurance benefit is a contract between you and your insurance company. Knowing your insurance benefits is your responsibility. Please

contact your insurance carrier with questions regarding your coverage. We must emphasize that as a medical care provider, our relationship is with you, our valued customer, not your insurance company.

If you have insurance coverage, you must present a valid insurance card at each visit. We will keep a copy of

the most recent insurance card in your medical record. If your insurance coverage changes, you must notify us

as soon as possible to avoid delay in your claims processing. If you fail to inform us of updated insurance,

balance on unpaid claims will become your responsibility.

**You are responsible for the deductible and estimated co-payments** (includes office visit and procedure co-pays), co-insurance and deductibles must be paid for at the time of service. This is part of your contract with your insurance company.

**Non-Covered Services**

Please be aware that some of the services you receive may be non-covered by your insurance carrier. These

services must be paid for at time of visit. Please read your enrollment booklet.

**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.

**Payment**

For your convenience, we accept cash, checks, and most major credit cards including: VISA, MasterCard, American Express, Discover, and Debit Cards. We reserve the right to refer your account to a collection agency if your account is over 90 days past due.

Balances older than 30 days may be subject to additional collection fees and interest charges of 1.75% per month or 21% annually will be charged on the unpaid balance of 60 days. If this presents a financial hardship, please ask to speak to out billing department. Failure to make payment will result in your account being sent to collections.

**Returned checks will be subject to a collection fee of $35.00**.

A 24 hour notice is required if you are unable to make your appointment. **There will be a $50 charge for no show appointments. Missed appointment (30 minutes) there will be a $50 charge, missed appointment (15 minutes) there will be $25 charge.** This charge is payable by you and will not be billed to your insurance. If you think you will be more than 30 minutes late for your appointment, we will be glad to reschedule you for another time.

Thank you for understanding our payment policy. Please let us know if you have any questions.

**I have read and understand the payment policy and agree to abide by its guidelines**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Print Name

**NOVA FOOT & ANKLE CENTER (NFAC)**

**NOTICE OF PRIVACY PRACTICES**

This notice describes how your health information may be used, disclosed and how you can access

this information. Please review it carefully.

At the NOVA Foot & Ankle Center we will always keep your health information secure and

confidential. We take precautions to secure electronic information. Firewalls and passwords are in place. A new law

requires that we continue to maintain your privacy, give you this notice and follow the terms of this notice.

The law permits our office to use or disclose your health information to those involved with your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company in order to be reimbursed for services.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. The NFAC has a written contract with each business associate that requires them to protect your privacy.

We may use information to contact you. For example, we may send newsletters or other information to the address you have provided us with. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone..

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

With the exceptions as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you to the requested office.

You have the right to see and receive a copy of your health information, with a few exceptions you will be required to give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. You will be required to make the requested changes in writing. If you wish to include a statement in your file, please give it to us in writing.

We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add the new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

**Acknowledgement**

I have read the above and I am aware that a copy of the NOVA Foot & Ankle Center Notice of Privacy Practices is available per my request.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If signing as a parent or guardian, please note the name of the patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_