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 **Patient Information and Consent**

**.**

**Patient Name**: \_\_\_\_\_\_\_\_\_­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth Date**:\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_ **Age:**\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City, St:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Zip** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alternate Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Gender :** M \_\_\_\_\_F\_\_\_\_\_

**SSN#**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **⁭ Martial Status Married ⁭ Single** ⁭Widow Other

**RACE: \_\_\_\_\_\_** African American \_\_\_\_\_ American Indian or Alaskan \_\_\_\_\_\_ Asian \_\_\_\_\_Hispanic \_\_\_\_\_ Mixed Race\_\_\_ White

\_\_\_\_\_\_\_ Other **Ethnicity:** \_\_\_\_\_\_\_\_\_\_ Hispanic \_\_\_\_\_\_\_\_ Not Hispanic \_\_\_\_\_\_\_\_Refuse to report

**Referred By:** (Please circle) Family member Phonebook Newspaper Insurance Internet

Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Weight** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Height** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ inches

**PRIMARY CARE DR**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CARDIOLOGIST**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIABETIC DOCTOR**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you want access to your online medical records through our office? \_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_No**

**If YES, please provide a valid Email Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You will receive an invite via the email provided above for the patient portal..

**\*\***Briefly describe the reason for your visit today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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**CONSENT & FINANCIAL STATEMENTS**

**Insurance and Authorization**

I certify that the information I have provided is correct. I also understand that the Foot & Leg Specialty Center files my insurance as a courtesy. I understand that I am responsible for my deductible. Co Payments, co-insurance or Non-covered services that will be collected at the time of service and or due within 60 days of insurance processing. .

**Patient or Authorized Person’s Signature Date**

**­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_**

**Policy Holder’s name: \_\_­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Self Spouse Dependent**

**DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SELF PAY**  If you are a self pay patient, you will be required to pay $100.00 for the office visit before services are rendered.

In addition, any remaining balance on your account will be collected at discharge.

**Patient consent for Treatment**

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by the Foot & Leg Specialty Center and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I understand that no guarantee has been or can be made as to the results of the treatments or examinations at The Foot & Leg Specialty Center/James V Stelnicki, DPM PA.
2. I consent to the use and disclosure of my/the patient’s protected health information for purposes of obtaining payment, treatment and health care operations consistent with the Foot & Leg Specialty Center notice of privacy practices, financial policy notice and release of information.
3. I authorize payment of medical benefits to The Foot & Leg Specialty Center/James V Stelnicki, DPM PA or their designee for services rendered.
4. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

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

**Patient or Authorized Person’s Signature** Date

**HIPPA Policy :** All patients are protected under the Federal Health Insurance Portability and Accountability Act .The federal law prohibits staff from discussing your medical information, appointments, tests and or treatment with anyone other than the patient, unless authorize a release of my protected health information to

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship

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