8328 Cleveland Ave NW North Canton, OH 44720 Phone: 330-494-4949 Fax: 330-494-4945

Last Name:________________________________First Name/M.I___________________________

Address:____City/St:________________Zip:________

Home Phone:_______-__________-__________ Cell: :______-_________-_________

Email: ____

Social Security (for billing purposes)_______-__________-__________ DOB:___/___/____ Sex: M/F

Employer/Occupation:____

How did you hear about us?

Doctor/urgent care: ________________________, Google/Internet __________, Facebook ____________,

Family/Friend__________, Insurance website ___________, Other _________________________________

Emergency Contact (Name/Phone Number)____

Primary Doctor____

Primary Insurance Company: ____

Subscriber's Name ☐ Self

____DOB___/___/_____SSN_____-____-_________ Secondary

Insurance Name:____

Pharmacy______________________________________Address________________________________

I understand and agree that (regardless of insurance status), I am responsible for the balance on my account for any professional services rendered. I certify that the information on this sheet is true and correct to my knowledge and will notify the office of any changes to the information above as soon as possible. I authorize the use of this form as my signature on file to be used to submit insurance claims on my behalf and authorize this office to act as my agent in helping obtain payment from my insurance companies. I authorize payment directly to this office. If payment is made to me by my insurance company in lieu of paying provider directly, the office has a legal obligation to collect that money from you.

____Signature ______________________________Date

REVIEW OF SYSTEMS
Please check if condition relates to your health

CONSTITUTIONAL

Weight Loss

Fatigue

Nausea/Vomiting

Chills

ENDOCRINE

Type 1 Diabetes

Type 2 Diabetes

Hyperthyroid

Hypothyroid

Osteoporosis

PSYCHIATRIC

Anxiety

Depression

Mood Swings

Family Stress

EYES

Glasses/Contacts

Eye Pain

Double Vision

Cataracts

RESPIRATORY

Cough

Wheezing

COPD

Difficulty Breathing

MUSCULOSKELETAL

Joint Pain/Swelling

Stiffness

Muscle Pain

Back Pain

Foot Cramps

Difficulty Walking

Loss of Balance

EAR/NOSE/THROAT

Difficulty Hearing

Ringing in Ears

Vertigo

Sinus Trouble

Sore Throat

GASTROINTESTINAL

Heartburn

GERD/reflux

Constipation

Diarrhea

Abdominal Pain

SKIN

Rashes

History of Ulcers

Itching/Burning Feet

CARDIOVASCULAR

Murmur

Chest Pain

Palpitations

Dizziness

Fainting Spells

Shortness of Breath

High Blood Pressure

Poor Circulation

IMMUNOLOGIC

Hives

Hayfever

Eczema

Psoriasis

FEMALE ONLY

Menopause

Irregular Menses

NEUROLOGICAL

Loss of Strength

Numbness

Tremors

Memory Loss

Height________________Weight_______________Shoe Size______________

Main Complaint for your visit today:

Duration:____

Allergies & Reactions * please list metal allergies

Surgeries:

Social History:

Do you drink alcohol? YES NO Drinks per day?_____________________

Do you smoke? YES NO Packs per day?-_____________________

Recreational Drug Use? YES NO

Marital Status Single____Married____Divorced___Widowed____Partnership____

How did you hear about our office?

Medications & Dosages:

Are you being treated by Pain Management? YES NO DOCTOR/FACILITY: ___________________________________

Privacy Policy: NORTH CANTON PODIATRY INC has provided me with the opportunity to obtain and read a copy of the privacy policies and procedures. The office of NORTH CANTON PODAITRY INC will not share your information with anyone other than another physician's office to coordinate your care. We may use medical information about you to provide medical treatment of services. Your written request on a HIPAA compliant release of information is required for all medical records request except in case of continuity of care.

____Signature____Date

FINANCIAL POLICY

NO Show Policy-We understand that emergencies come up. Please call us as soon as possible to cancel appointments. If no call is made, your visit may incur a $25.00 fee for each missed visit. A fee of $100.00 will be assessed if a surgical procedure is a "no-show". We participate in MOST insurance plans. If you are not insured by a plan that we participate with, PAYMENT IN FULL is required at each visit prior to being seen by provider. You must show your most current insurance card at every visit. If you do not have a current card, you may be rescheduled at the discretion of the office. You are responsible for knowing what services are covered by your insurance carrier. Please contact your insurance company with any questions you may have regarding your coverage and benefits. You are ultimately responsible for your bill. In the event that a payment is returned for non-sufficient funds, there will be $30.00 additional fee that is not covered by insurance. NORTH CANTON PODIATRY INC is participating with Medicare. As a Medicare patient, you are responsible for the annual deductible. Some secondary insurances cover this service, however many do not. It is your responsibility to understand your insurance plan guidelines. If you no-show more than 3 time with NORTH CANTON PODIATRY INC, you will be discharged from the practice indefinitely.

****WORKER'S COMPENSATION- OUR OFFICE DOES NOT ACCEPT WORKER'S COMP CLAIMS****

In the event that you require surgery with the provider, that will be a separate charge. I understand that I am financially responsible for all charges not covered by insurance and I guarantee the balance to be paid by credit card, cash, or check. I understand that the office agrees to bill insurance as a courtesy, and I must submit the proper and most up-to-date information as needed to ensure payment for services rendered to me.

REFERRALS/AUTHORIZATIONS: some insurance plans require a referral be made in order to be seen by a specialist. Each plan is different and carries its own set of guidelines regarding referrals. It is your responsibility to verify if this is needed for your service here. If a claim is denied for lack of referral- the entire balance will your financial responsibility.

Your participation with your insurance company is a contract and you are legally obligated to make a reasonable effort to pay your copays, coinsurance, deductibles, etc. If your account exceeds $150.00, you may be required to pay in full or set up a payment plan in order to keep receiving care by the provider.

COPY SERVICE: NORTH CANTON PODIATRY INC will provide copies of patient records at the patient's request. 1 copy will be provided free of charge. Subsequent copies are subject to fee $1.00/page. Payment is required prior to release of records. This request will only include records created by NORTH CANTON PODIATRY INC. Copies of records may be subject to copy service section 3701-741 of the revised code at the time the copies are provided. Any paperwork that needs to be completed by the provider, i.e. short-term disability, etc may be subject to a $20.00 paperwork fee. **ALL DURABLE MEDICAL EQUIPMENT IS NON-RETURNABLE**

______________________________________**PATIENT NAME (PRINT)**________________________________**DATE**

____**SIGNATURE OF PATIENT/RESPONSIBLE PARTY**