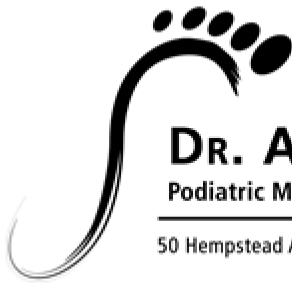

DR. ADAM KLEIN, DPM, PC
Podiatric Medicine and Foot Surgery • *Diplomat, American Board of Podiatric Medicine*
50 Hempstead Avenue • Lynbrook, NY 11563 • Tel: 516.593.1941 • Fax: 516.593.2224 • www.DrAdamKlein.com

**Please give your insurance cards and photo ID to the nurse.**

**Please Print** **Date** ________________________

**Name (First)**_____________________**(MI)**___**(Last)**_____________________________

**Address**_____________________________**City**_____________**ZipCode**_________

**Home Phone**________________________ **Cell Phone** __________________________

**Birth Date**_______________ **Sex** M / F **Work phone**__________________

**E-mail** ______________________________________ **Marital Status:** S M D W

**Occupation**_________________________________ **Shoe Size?**

**Primary Insurance Company:**______________________________________________

**Secondary Carrier (if any)**_________________________________________________

**Primary Care Doctor**_________________________________ **Last Visit**___________

**How were you referred to the office?**________________________________________

Smoking Status: Never Smoked ☐ Former Smoker ☐ Smoker ☐

**Have you ever seen a Podiatrist?** ☐ No If so what for what and when:__________
________________________________________

**Allergies: (Please check all that apply):** ☐**NONE** ☐Aspirin ☐Iodine (shell fish) ☐ Penicillin Codeine ☐Latex ☐Sulfur ☐Tape ☐Other Antibiotic ☐Other:___________________

**Medications:** ☐ **NONE**

**1.**__________________________________ **5.**_________________________________

**2.**__________________________________ **6.**_________________________________

**3.**__________________________________ **7.**_________________________________

**4.**__________________________________ **8.**_________________________________

**Medical History:** (Please check all that apply): ☐ **None**

☐ Anemia
☐ Alcoholism
☐ Depression
☐ Gout
☐ High blood pressure
☐ Kidney disease
☐ Neuropathy
☐ Poor circulation
☐ Stomach ulcer

☐ Anxiety
☐ Asthma
☐ Diabetes
☐ Heart disease
☐ High Cholesterol
☐ Liver disease
☐ Osteoporosis
☐ Psoriasis
☐ Other_____________________

☐ Arthritis
☐ Currently pregnant
☐ Excessive bleeding
☐ Heart murmur
☐ HIV
☐ Mitral Valve Prolapse
☐ Phlebitis
☐ Scar former

**Podiatric History:** Do you currently (or in the past) suffer from any of the following? (check all that apply):

☐ Abnormal foot posture
☐ Achilles tendon pain
☐ Ankle instability (easily twisting injury)
☐ Ankle swelling or stiffness
☐ Athletes foot
☐ Blisters
☐ Bunions
☐ Crooked toes (hammertoes)
☐ Diabetic foot evaluation
☐ Excessive perspiration from feet
☐ Flat feet
☐ Foot pain
☐ Foot Surgery
☐ Foot ulcer

Heel or arch pain (adult or child)
☐ High arch
☐ Infection of foot/leg
Ingrown nail
☐ In toe or Out toe gait
☐ Nerve pain
☐ Neuroma
☐ Numbness or tingling in foot or leg
☐ Pain in feet or legs with activity
☐ Pain in feet when getting out of bed
☐ Thick toenails with pain
☐ Trouble running
☐ Warts
☐ Other:___________________________

**Have you ever had any type surgery? (If so what type and when?)** ☐ No

_____________________________________________________________________

**Have you had a Flu Shot?** Y/N **Have you had a Pneumonia Shot?** Y/N

**Privacy Information Preferences:**

-Were you offered a copy of the HIPPA Privacy Notice? Yes No
-Can we send mail to address on file? Yes No
-Can we call the phone numbers on file? Yes No
-Can we leave voicemail or answering machine message? Yes No
-Can we email reminders? Yes No
-Do you have a living will or advanced directives? Yes No
-Do you want to be exempt from public reporting? Yes No
Who can we leave messages with? Spouse Child Parent Other_______

# HIPAA & Financial Responsibility

I certify the information that I have provided is correct. I hereby give permission to Dr. Adam Klein, DPM, PC to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. 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. I have received, or reviewed a copy of the HIPAA form.

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. I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt equal to 40% of the balance due. I consent to receive calls from Dr. Adam Klein, DPM, PC, collection agency/attorney representative(s) should my account be placed for collection at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system." 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. There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party:________________________________________

Printed Name of Patient/Responsible Party:____________________________ Date:____

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