

Rochester Center for Foot & Ankle Surgery
1135 West University Dr, Ste 235
Rochester, MI 48307
Phone: 248-651-0162
FAX: 248-651-1022

Medical Center Footcare Associates
29433 Ryan Road
Warren, MI 48092
Phone: 586-574-0500
FAX: 586-574-2694

Zeeshan S. Husain, DPM
Charles G. Kissel, DPM
Michael S. Schey, DPM

Angela E. Stoutenburg, DPM
Sarnarendra Miranpuri, DPM MD

WELCOME TO OUR OFFICE

Please answer these questions to help us become better acquainted.

NAME: _____ AGE: _____ SEX: MALE FEMALE

BIRTHDATE: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____) _____ WORK PHONE: (____) _____

MARITAL STATUS: SINGLE MARRIED WIDOW DIVORCED SEPARATED

EMERGENCY PHONE: (____) _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

EMPLOYER'S NAME: _____ PHONE: (____) _____

EMPLOYER'S ADDRESS: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

HAVE YOU HAD PREVIOUS FOOT CARE BY A SPECIALIST? YES NO

IF YES, BY WHOM? _____

WHAT FOOT/ANKLE COMPLAINT BRINGS YOU TO OUR OFFICE? _____

ARE YOU PREGNANT AT THIS TIME? YES NO

ARE YOU TAKING ANY MEDICATIONS? YES NO

IF SO, PLEASE LIST THEM BY NAME: _____

DO YOU HAVE ANY ALLERGIES: YES NO

IF SO, PLEASE LIST THEM BY NAME: _____

ARE YOU DIABETIC? YES NO IF SO, WHICH TYPE?: TYPE I TYPE II

INSURANCE INFORMATION: PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARDS SO SHE CAN MAKE A COPY OF THEM – THANK YOU.

Subscriber's Name (if not patient)

Subscriber's Date of Birth (if not patient)

Patient's Signature

Date

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FINANCIAL POLICY

1. We participate with many insurance plans including Medicare and Blue Cross. We will accept your plan's approved amount as payment in full for all services, which fall under these contracts. We are required to collect all deductibles, co-pays, and any non-covered services directly from you, the insured patient.
2. There are many differences in coverage from insurance policy to insurance policy. We will always attempt to determine coverage before treatment, but in some cases we cannot. You are responsible for any balance on your account not paid by your insurance.
3. We will submit your bills to your insurance company for you directly unless you request otherwise.
4. Balances are due on the date that services are provided unless prior arrangements have been made.
5. Statements are mailed monthly and reflect unpaid balances as well as balances transferred to you (co-pays and deductibles) as determined by your insurance company after they have made their payments. Unfortunately, this can take *several* months.
6. Payment is expected upon receipt of your statement. If there are questions regarding the balance, or if you cannot pay your balance, please call our office and speak to our billing staff immediately.
7. The coverage of Medicare part B is as follows:

“Each calendar year (beginning January 1 and ending December 31st) a Medicare beneficiary must satisfy a deductible of \$100.00 for covered services based on physician's reasonable charges. Medicare will assume liability for paying 80 percent of the reasonable charges for covered services during the remainder of that year. The deductible plus 20 percent (referred to as coinsurance) is the beneficiary's responsibility. This may or may not be paid by the patient's secondary insurance coverage. On January 1 of each year the patient becomes responsible for a new deductible.”

Signature: _____

Date: _____

PLEASE READ AND SIGN THE FOLLOWING

RELEASE TO TREAT

I hereby give permission to Drs. Zeeshan Husain, Charles Kissel, Michael Schey, Angela Stoutenburg, and Sarnarendra Miranpuri or any designated person to examine and treat my feet as necessary, and to video tape and/or audio tape (i.e., record or tape) that material and/or information which the doctor deems necessary for his/her records.

I hereby give permission as parent or legal guardian for _____ to be treated by Drs. Husain, Kissel, Schey, Stoutenburg, and Miranpuri, or any designated person to examine and treat as necessary, today and on any future dates.

Signature: _____

Date: _____

RELEASE TO INSURANCE

I hereby assign all medical benefits including major medical benefits to which I am entitled including Medicare, private insurance and any other health plan to Drs. Husain, Kissel, Schey, Stoutenburg, and Miranpuri. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignees to release all information necessary to secure payment.

Signature: _____

Date: _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (please print)

Date

Parent or Authorizer Representative (if applicable)

Signature