FOOT CLINIC OF WEST BEND
LISA G. KORNELY, DPM
2358 W. WASHINGTON STREET
WEST BEND, WI 53095

PATIENT INFORMATION

Date_____
Last Name_____
First Name_____ __ MI ____
Address_____
City_____
State_____ Zip _____
Sex: □ M □ F Age _____
Birthdate_____
SSN_____
Primary Language_____
Race:
□ White □ American Indian □ Alaska Native □ Asian
□ African American □ Native Hawaiian/Pacific
Ethnicity: _____
Marital Status:
□ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered
Primary Physician _____
Date Last Seen _____
Patient Employer _____
Spouse's Name _____
Spouse's Birthdate_____
Spouse's Employer_____

Whom may we thank for referring you?

_____

INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Company _____
Identification number _____
Subscriber Name _____
Birth date _____

Insurance Assignment & Release

I certify that I have insurance coverage with _____ and assign directly to Dr. Kornely all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Kornely may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when I inform the office in writing.

_____
Signature of Beneficiary, Guardian, Personal Representative

_____ _____
Date Relationship to Beneficiary

CONTACT INFORMATION

Home Phone (_____)_____
Cell Phone (_____)_____
Work Phone (_____)_____
E-mail _____
Emergency Contact:
Name_____
Relation_____
Home Phone (_____)_____
Cell Phone (_____)_____

PODIATRY HISTORY

What is your chief complaint for which you came to be treated? _____
_____
When did the pain/discomfort begin?
_____
Out of a 10 pain scale (1-least/10-worst), how would you rate your pain? _____
Have you been treated by another physician for this problem? _____

MEDICAL HISTORY

(Check all that *previously* or *currently* apply to you)

□ None
□ AIDS/HIV
□ ALLERGIES TO ANESTHETICS
□ ANEMIA
□ ANGINA
□ ARTHRITIS
□ ASTHMA
□ BACK PROBLEMS
□ BLEEDING DISORDERS
□ CANCER (type:_____)
□ HIGH CHOLESTEROL
□ CIRCULATION PROBLEMS
□ DIABETES
□ EAR PROBLEMS
□ EPILEPSY
□ EYE PROBLEMS
□ GOUT
□ HEADACHES
□ HEMOPHILIA
□ HEPATITIS/JAUNDICE
□ HIGH BLOOD PRESSURE
□ KIDNEY PROBLEMS
□ LIVER DISEASE
□ NEUROPATHY
□ RESPIRATORY PROBLEMS
□ SINUS PROBLEMS
□ SKIN ULCERS
□ STOMACH ULCERS
□ STROKE
□ SWELLING
□ THYROID PROBLEMS
□ VARICOSE VEINS
□ HEART
OTHER:
_____
_____

SURGERIES

(List *all* surgeries you have had)

□ None

_____
_____
_____
_____
_____
_____
_____
_____
_____

HOSPITALIZATIONS

(List hospitalizations other than for surgeries)

_____
_____
_____
_____

MEDICATIONS

(List **all** medications, dosages, & frequency
including **over-the-counter medications** and **vitamins**)

□ None

_____
_____
_____
_____
_____
_____

Pharmacy Name: _____
Pharmacy Location:_____

ALLERGIES

(Circle all that apply to you)

□ None
Adhesive tape
Anticoagulant Drugs
Aspirin
Codeine
Demerol
Iodine
Local Anesthetics
Novocaine
Penicillin
Seafood
Sulfa
Other: _____
_____

SOCIAL HISTORY

Smoking Status:
___ Smoker, every day
___ Smoker, some days
___ Former smoker
___ Never smoked

(IF tobacco user, check what types)
____ Cigarettes
____ Cigars
____ Pipe
____ Chewing Tobacco

Alcohol Use: ___never ___occasional ___frequent
Type: ____Beer ____Wine ____Hard Liquor

Height _____ **Weight** _____ **Shoe Size** _____

FAMILY HISTORY

Mother
□ Living Age____ Health issues: _____
□ Deceased Age____ Cause: _____
Father
□ Living Age____ Health issues: _____
□ Deceased Age_____ Cause: _____
Other (Relation _____)
□ Living Age____ Health issues: _____
□ Deceased Age_____ Cause: _____

Financial Policy for Kornely Podiatry LLC

1. It is your responsibility to keep our office up to date on your insurance and contact information. As a courtesy, we will file with your primary and secondary insurance. It is your responsibility to make sure that your insurance company(s) have your most recent address, contact information and coordination with other insurance companies.
   IT IS YOUR RESPONSIBILITY TO BE CERTAIN WE ARE IN-NETWORK WITH YOUR PLAN.
   IT IS YOUR RESPONSIBILITY TO KNOW THE TERMS OF YOUR INSURANCE PLAN AND UNDERSTAND YOUR PLAN BENEFITS.

   Remember, you (and/or your employer) pay the monthly insurance premiums. Your insurance company is accountable to you. Do not hesitate to contact them if you disagree with their payment or do not understand the benefits of your insurance.

2. At the time of service, we will collect your copayment (if applicable) and may collect toward your co-insurance and unmet deductible. Accepted payment methods are Cash, Check, MasterCard, Visa and Discover.
   We cannot waive deductibles, coinsurances, or copays that are required by your insurance. This is a violation of insurance rules.

3. **SELF PAY:** Payment in full is due at the time of service if you do not have health insurance.

4. **REFERRALS**: It is your responsibility to know if your insurance plan requires a referral and to obtain one from your primary care physician or from your insurance to have forwarded to our office prior to your appointment.

5. **PATIENT BILLING:** You will be sent up to three statements for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. Should your account be forwarded to collections, you agree to also reimburse us the fees of any collection agency, which is 40% of your balance.

   An additional $35 will be added to your statement if a check is returned for insufficient funds.

6. **MISSESD OR CANCELLED APPOINTMENTS**:
   We will not charge you for a missed or cancelled appointment, however, we may restrict you from scheduling at our office if any of the following occur as it prevents other patients who need care from being seen:
   -You no call/no show to your 1st appointment
   -You no call/no show for 2 or more appointments
   -You cancel 2 or more appointments with less than a 24-hour notice

_____ _____

Printed Name Date

_____

Signature

KORNELY PODIATRY, LLC
LISA G. KORNELY, DPM
2358 W WASHINGTON STREET
WEST BEND WI 53095-2118
Phone: (262) 335-2930 Fax: (262) 335-2931

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

Are you familiar with the HIPAA Laws regarding privacy of your medical records?
Would you like a copy of our office's Privacy Practices?
If yes, please ask the front office staff and they will provide you with a copy or review the Notice of Privacy Practices on the website.
Please complete this form verifying that we have offered and/or given you a copy of our office's privacy practices.

I have been offered the Notice of Privacy Practices and I have been provided with an opportunity to review it.

Print Name: _____

Date of Birth: _____

Today's Date: _____

Signature: _____