*Dr. Brian Kashan  *Dr. Chanelle Carter  Dr. Robert Nwosu

*Board Certified, American Board of Foot and Ankle Surgery

PATIENT INFORMATION UPDATE

WELCOME TO OUR OFFICE!

Please complete the entire form and if necessary, ask us for assistance.

Name:			Birthdate:	
Address:				
City:	State:		Zip:	
Home Phone:		Cell Phone:		
Email Address:				
Emergency Contact:			Phone:	
Primary Physician:		Date of last visit:		
Primary Insurance *(please attach card)*:				
Secondary Insurance *(please attach card)*:				
List Current Medications				
Current Medical Conditions ***(please check all that apply)***				
o Heart	o Blood Pressure	o Diabetes	o Circulation	o Liver
o HIV	o Breathing	o Cancer	o Kidney	o Ulcers
o Other:				
Allergies				
Prior Surgery				
Family History				
Do you use:	O Tobacco	O Alcohol	O Drugs	
Current foot complaint:				
How long have you had this condition?				
Any prior treatment?				
Shoe Size:	Weight:	Height:		
Have you had: Flu Vaccine	O Yes O No	Pneumonia Vaccine	O Yes O No	
Do you have diabetes: O Yes O No	Last glucose reading:	Last A1C:		
Is your visit today related to any injury on the job or accident" O Yes O No				

Please read the insurance and financial disclosure on next page.

PATIENT UPDATE FORM

(This form must be signed)

INSURANCE AND FINANCIAL DISCLOSURES AND POLICIES:

I hereby authorize direct payment of surgical and medical benefits on my behalf to the provider of these services that would otherwise be payable to me if I did not make this assignment. I understand that I am personally responsible to the physician for charges not covered by my insurance agreement. I also understand that if my account becomes delinquent, I will be responsible for any costs of collection of my account, including collection fees and attorney costs. A $5.00 per month re-invoicing fee may apply to all accounts 60 days past due. I permit a copy of this assignment to be used in place of the original for purposes of billing.

I acknowledge that if my insurance requires a referral, whether it be paper or electronic, that I am responsible for getting an up to date and valid referral. I understand that failure to do so may result in my charges being my responsibility and that payment will be due from me directly.

I understand that I am responsible for providing correct, accurate, and current insurance information at all times. If, as a result of my not providing this information, my claim is denied, I understand that I am responsible for the total amount of my bill to be paid within 30 days of notice, without exception.

I understand that I am responsible for any bank charges or fees for returned check or payment.

There is a $25 charge for missed or cancelled appointments without 24 hour notice

There may be a charge for medical records and the completion of forms as allowed by law.

Deductibles and all co-pays are due and collected at the time of service.

You must have a valid ID and insurance card to be treated.

All **non-covered** services are due at the time of service and will not be billed to your insurance.

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital generated. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition, to use x-ray examination, or photographs as necessary.

I give Plaza Podiatry, (Dr. Brian Kashan, D.P.M., P.A) permission to obtain and release medical information to insurance companies and referring physicians. I have read the following and understand and agree to Dr. Brian Kashan, DPM, P.A.'s office policy.

_____

DATE **SIGNATURE OF PATIENT OR LEGAL GUARDIAN**

**If not patient, relationship to patient:

___Parent ___Power of attorney ___Legal Guardian ___ Other: