Dr. Keith J. Kalish
Board Certified Medical & Surgical Foot Specialist
Podiatrist

Last Name: _____ Jr/ Sr First Name:_____

Date of Birth: _____/_____/_____ Sex : male/female

Social Security Number: _____-_____-_____ (SS # is for identification purposes only)

Address on file with Insurance:

Street: _____

City:_____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Email Address: _____

Spouse/Parent/Guardian: _____

Alternate/Northern Address:

Street: _____

City: _____ State: _____ Zip: _____

Emergency Contact Information:

Name: _____ Phone #: _____ Relationship: _____

Primary Care Doctor: _____ Cardiologist: _____

I give Keith J. Kalish D.P.M. permission to check my prescription history. Initials: _____

Pharmacy Name: _____ Location: _____

How did you hear about us? *Check all that apply* Referred by: _____

___ Insurance ___ Family/Friend ___ Sign ___School Program

___ Yellow Pages ___ Health Fair ___ 32963 ___ VB Magazine

___ Hometown News ___ Newspaper ___ Internet/Website ___ Doctor: _____

___ Church Bulletin ___ Community Publication ___ Other : _____

Patient Name: _____ Account #: _____

Your right regarding release of information

You have the right to choose to whom we may release your health information with regards to your family members. Please indicate who we may release medical information to by checking below:

_____ No one _____ Individuals listed below

Name(s): _____ Relationship: _____

Release of Information

"I authorize the release of my medical information to my primary care or referring physician and to consultants as necessary to process insurance claims, insurance applications, and prescriptions as so noted on my patient registration form. I also authorize payment of medical payments to Keith J. Kalish D.P.M." If any of the information changes, I will notify the office of all changes in written notification.

Privacy Practices

I have received the Privacy Practice Acknowledgment and I have been provided an opportunity to review it. I hereby give permission to Dr. Kalish to administer treatment and perform minor operative procedures as may be deemed necessary in the diagnoses and/or treatment of my conditions. I authorize payment of benefits to Dr. Keith J. Kalish for medical services received. I authorize release of any medical information necessary to process this claim. I authorize Dr. Kalish to request and/or release information from any other medical office if it is relevant to my medical treatment. This includes all information including buit not limited to mental health, substance abuse, HIV, AIDS, and Hepatitis.

By signing below I acknowledge, understand, and agree to all statements above:

X _____ Date: _____

Medicare patients only:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to the payer if they require it for proper consideration of a claim. Please read and sign the statement:

"I authorize any holder of medical or other information about me to be released to the Social Security Administration and Centers for Medicare and Medicaid Services or it's intermediaries or carriers any information needed for this or related Medicare claim. I permit copy of this authorization be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare benefits apply. "

Signature exactly as it appears on your Medicare card:

X _____ Date: _____

Patient Name: _____ Account #: _____

Keith J. Kalish D.P.M. P.A. wants to assist you in the financial management of our relationship. Please be advised this is not an all inclusive list. Benefit verification will be provided as a courtesy and is not a guarantee of payment. Be assured that we will be ethical and fair concerning any billing or collection concerns you may have. If you have any questions, please speak with our billing department.

Participating Plans

- Our billing department will file your insurance for services rendered.
- The patient is responsible for presenting all current insurance cards at the time of service.
- The patient is responsible for co-pays, deductibles, and co-insurance at the time of service. Medicare patients will be responsible for the annual Medicare deductible then 20% of Medicare allowable fees for each service (if a secondary insurance does not cover these).
- The patient is responsible for knowing their policy coverage, deductible, coinsurance etc.
- Patient is responsible for insurance follow up with their plan regarding student status forms, annual employer claim forms, accident/injury information, and terminated insurance plans.

Non-participating Plans

- The patient is responsible for all out-of-network patient responsibility at the time of service unless other payment arrangements have been made. This would include any coinsurance, deductible, and the difference between carriers allowable and our standard fee.

Self-pay

- Patients with no insurance coverage will be considered self-pay.
- Payment is due at the time services are rendered unless other arrangements have been made in advance.

Collections

- Collection notices begin 30 days after the first statement is received if payment has not been made. A $10 fee is assessed if payment is not received within 30 days from initial statement and each statement there after.
- All unpaid balances will be sent to an outside collection agency after all practice efforts have been exhausted. This will result in a negative credit rating. All reasonable attorney fees and collection cost will be the patient's responsibility and the even of default payment. A $50 collection fee will be charged to the patient's account for all outside collection activity.

Auto claims

- We must have authorization from your auto insurance along with an adjuster's name and a claim number. We must have a copy of your health insurance card to bill your health insurance in the event our office received a benefits exhausted letter from your auto insurance company. Our practice will not accept letters of protection from an attorney's office and will not bill a third party for a claim. The patient is responsible for the balance after auto and health benefits have been processed.

Deductibles and Co-pays

- If we participate with your insurance, we must collect any deductible, co-insurance, and/or co-pay at the time of service. If you are unable to provide payment we reserve the right to reschedule your appointment.

Returned check fee

- A fee of $25 will be charged to the patient's account for a returned check from the bank.

Medical Records

- The fee for medical record copies is $1 per page for the 1st 25 pages and $.25 per additional page

Form completion

- The fee to complete forms (Disability, FMLA, ect.) is $25

____ I DO NOT have health insurance
____ I HAVE health insurance coverage with _____

I, the undersigned, agree to be responsible for any charges incurred by me or not payable by my insurance company. I also agree to be responsible for any legal fees and/or court costs incurred as a result of my failure to pay for services rendered.

X _____ Date _____

Patient Name: _____ Account #:_____

Reason for today's visit:

_____

_____

How long has this been a problem?

_____

Is this problem related to an injury? _____ Yes _____ No

If yes, was this related to: _____ Work _____ Auto _____ Other

Please list any conditions for which you see a physician or take medication:

_____

_____

Please list prescription medications you currently take or provide a list:

Allergies to medication:

Are you allergic to latex gloves? _____ No _____ Yes

Social History:

Do you smoke? _____ No _____ Yes If no longer smoking, quit date: _____

Do you drink alcohol? _____ No _____ Yes If yes, how often? _____

Credit Card on file Policy

Kalish Foot Care requires each patient to keep a credit or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. Your credit card information is kept confidential and secure.

This policy states that your claim will be filed to your insurance company, payment will be posted and a statement will be sent to you for any balance. You will have 30 days to make payment from the statement date. Your card will only be charged if there is any remaining balance 21 days from the statement date.

Note: You will still be responsible for any known co-pays, co-insurance, and deductible at the time of service.

Patient Name (please print): _____ Account #:_____

Please circle: AMEX VISA MASTERCARD DISCOVER

Credit Card Number: _____

Expiration Date: _____/_____

CVV: _____ *(Security code on back of card)*

Cardholder Name: _____

Billing Address:

Street: _____

City: _____ **State:** _____ **Zip Code**: _____

Signature of Cardholder (if different from patient):

X_____ **Date:** _____

I, the undersigned, authorized and request Kalish Foot Care to charge my credit card indicated above, for balance that is due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Kalish Foot Care.

Patient Signature: _____ **Date:** _____