

# LAKWOOD AMBULATORY FOOT CENTER

Dr. Stephen Smik  
3386 Warren Road, Cleveland, OH 44111  
216-941-0233

## Patient Information

This information is important for our records, and your health

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Soc. Security Number: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F Marital Status: S M D W

Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Primary Insurance Co: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

How Did You Hear About Us, Or Whom May We Thank For Sending You To Our Office:

\_\_\_\_\_

Previous Foot Doctor: Y N if yes who: \_\_\_\_\_

What is your Chief Foot Complaint: \_\_\_\_\_

\_\_\_\_\_

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Please fill out completely

Name \_\_\_\_\_ Date \_\_\_\_\_ Shoe size \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Duration of problem: \_\_\_\_\_ Have you had previous treatment? \_\_\_\_\_

Is this injury related? \_\_\_\_\_ Date of injury: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

## MEDICAL HISTORY

DO YOU HAVE OR EVER BEEN TREATED FOR THE FOLLOWING (check all that apply):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Acid Reflux          | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Osteoporosis        |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Fainting spells          | <input type="checkbox"/> Pace maker          |
| <input type="checkbox"/> Anxiety              | <input type="checkbox"/> Frequent infections      | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Phlebitis           |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Gout                     | <input type="checkbox"/> Polio               |
| <input type="checkbox"/> Back problems        | <input type="checkbox"/> Heart Conditions         | <input type="checkbox"/> Psoriasis           |
| <input type="checkbox"/> Bleeding problems    | <input type="checkbox"/> Heart attack             | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Bronchitis           | <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> Sciatica            |
| <input type="checkbox"/> Cancer _____         | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Stomach Ulcers      |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Depression           | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Thyroid             |
| <input type="checkbox"/> Diabetes _____       | <input type="checkbox"/> Kidney disease           | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Eczema               | <input type="checkbox"/> Lupus                    | <input type="checkbox"/> Vascular disease    |
| <input type="checkbox"/> Emphysema            |   |  |

### Social History

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Alcohol _____    | <input type="checkbox"/> Other _____   | <input type="checkbox"/> Recreational Drugs |
| <input type="checkbox"/> Smoker _____ PPD | <input type="checkbox"/> None of these | <input type="checkbox"/> Exercise           |

### ALLERGIES (check all that apply)

- |  |                                     |                                 |
|--|-------------------------------------|---------------------------------|
| <input type="checkbox"/> Aspirin         | <input type="checkbox"/> Novocain   | Foods _____                     |
| <input type="checkbox"/> Morphine        | <input type="checkbox"/> Hay Fever  | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Tapes/adhesives | <input type="checkbox"/> Demerol    | <input type="checkbox"/> Sulfur |
| <input type="checkbox"/> Codeine         | <input type="checkbox"/> Penicillin | Other _____                     |

MEDICATIONS ( Please include dosage and frequency): A list can be copied. \_\_\_\_\_

PRIOR SURGERIES: \_\_\_\_\_

FAMILY MEDICAL HISTORY: Diabetes Cancer Strokes Heart Disease Other explain \_\_\_\_\_

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**Authorization to Treat**

Patient Name(Print): \_\_\_\_\_  
I hereby give my permission to Stephen Smik, DPM to administer treatment and perform such minor operative procedures as may be deemed necessary in the diagnosis and treatment of my foot conditions. I understand that if my insurance company denies or refuses payment for any services rendered by Dr. Smik that I or the responsible party is liable for the payment of all unpaid balances.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature/Gaurdian Date

**Medical Insurance Release Authorization**

In order for us to submit a claim for services covered under your insurance policy, we must have your authorization to release medical information to your insurance carrier. Please read and sign the following statement:

I authorize Dr. Stephen Smik and to whomever he designates to furnish my insurance company (or Medicare) with all the necessary information regarding my present illness or injury. I also authorize payment of medical benefits to Dr. Stephen Smik, and/or Lakewood Ambulatory Foot Center, Inc. for medical supplies or services provided, with the understanding that any overpayment will be reimbursed to me promptly. A photocopy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
Name Signature  
\_\_\_\_\_  
Date Signature of parent or guardian

Due to HIPPA regulations, no patient information will be released without your written permission.

# LAKEWOOD AMBULATORY FOOT CENTER

## Patient Payment Policy

Thank you for choosing our practice. It is our belief that establishing a written financial policy is mutually beneficial to all parties. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing excellent healthcare services to our patients.

We participate with many insurance plans. Each insurance plan has different benefits for you as well as different financial obligations. Not all insurance policies cover all services. It is ultimately your responsibility to check with your insurance company to determine covered benefits.

The following are our policies relative to financial responsibility:

- **New patients must present an insurance card and photo identification.** New patients without an insurance card will be considered a cash account. Payment is due at time of service.
- Please present your insurance card(s) at each visit to our office.
- **Payment is expected at the time services are rendered.** This includes copays, deductibles and coinsurance, as well as payment for any non-covered or over the counter items.
- You may be charged a no-show fee of \$25.00 for any appointments missed, not cancelled or rescheduled with at least 24 hours notice.
- Prior balances on your account must be paid in full within 60 days unless other arrangements are made **in advance and in writing** with the office manager.
- Accounts may be turned over to a collection agency for any balances past due 60 days or more.
- A service charge of \$20.00 will be assessed for returned checks, refiling of insurance due to *incomplete or incorrect information given at the time of the appointment or for accounts turned over to collections.*
- I understand that I will be legally responsible for all collection costs associated with the collection of this account including court costs, reasonable attorney fees, and all other expenses incurred with collection if I default on any unpaid balance.
- In the case of services provided to patients under the age of 18, the parent, guardian or legal representative that initiates the services for the minor will be responsible for payment. We do not bill another individual or estranged spouse for payment.

I hereby authorize Lakewood Ambulatory Foot Center to file all medical claims with any and all insurances in which we participate. I hereby authorize payment of insurance benefits to me be made to Lakewood Ambulatory Foot Center. I authorize release of any information related to any claims to all my insurance companies or other relative parties. I further understand that if my insurance company denies any or all medical services as "non-covered", "coverage terminated", "pre-existing", or "not a covered member", I will be responsible for full payment within 30 days of said denials, or within 30 days of the first billing statement sent by our office following the receipt of said denial(s). I understand that we will not file any claims for non-covered or over the counter items.

I fully understand the above policies and agree to be financially responsible for any and all incurred charges resulting from medical services rendered.

**Upon arrival at our office, you will be asked to read and sign this form prior to receiving any services. A copy of the signed form will be provided to you.**

Signature \_\_\_\_\_ Date \_\_\_\_\_