FootCare Specialists, Inc.
A Podiatry Group

David J. Kaplan, D.P.M.
Chief Podiatrist

Please print clearly and do not skip any information

FIRST _____ MIDDLE _____ LAST _____

BIRTH DATE ____/____/____ AGE _____

SS# ____--____--_____ SEX M / F

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE # (____) ____--_____ WORK # (____) ____--_____

EMPLOYER _____ TYPE OF WORK _____

SPOUSE _____ WORK # (____) ____--_____

INSURANCE #1 _____

POLICY # _____ GROUP # _____

NAME OF INSURED _____ RELATION _____

DATE OF BIRTH OF THE INSURED _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE # (____) ____--_____

INSURANCE #2 _____

POLICY # _____ GROUP # _____

NAME OF INSURED _____ RELATION _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE # (____) ____--_____ PHARMACY _____

PHYSICIAN _____ PHONE # (____) ____--_____ LAST VISIT _____

EMERGENCY NAME _____ PHONE # (____) ____--_____

WHOM MAY WE THANK FOR REFERRING YOU _____

I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment.

I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I am financially responsible for non-covered services.

I hereby give permission to the doctor to administer treatment and perform such general procedures, as he may deem medically necessary in the diagnosis and/or treatment of my condition.

SIGNATURE _____ DATE _____

I have read and agreed to the above statement

David J. Kaplan, D.P.M.
Chief Podiatrist

Diplomate,
American Board of
Podiatric Surgery

Fellow,
American College of
Foot and Ankle Surgeons

Qualified Medical Examiner
State of California
QME # 902342

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ELIGIBILITY WAIVER FORM

Positive verification of your coverage cannot be made at this time. You will receive services with the understanding that in the event that your coverage is not effective, you will be billed and held financially responsible for services rendered.

I understand that if this or any other visit precedes or exceeds the effective dates assigned to my enrollment by my employer, I will be held responsible for all related fees incurred. I also understand that if I fail to obtain preauthorization as required by my health insurance plan prior to receiving services, I will be responsible for paying any related charges. I also understand I will be responsible for paying all related fees incurred for any services received which are not a benefit stipulated in my insurance evidence of coverage.

I have read the above and understand my possible financial responsibility to Dr. David J. Kaplan and FootCare Specialists, Inc., and hereby affix my signature as an acknowledgment of this understanding.

_____

Patient Signature

_____

Date

_____

Receptionist/Witness

Outpatient Clinics

39 N. San Mateo Dr., #4
San Mateo, CA 94401
(650) 343-7775
Fax (650) 343-3954

725 Main Street
Half Moon Bay, CA 94019
(650) 726-4070

Skilled Nursing and Administrative Headquarters

39 N San Mateo Dr # 4
San Mateo, CA 94401
(650) 343-7775
Fax (650) 343-3954

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Examiner
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FootCare Specialists, Inc

PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

As our patient, you are responsible for all authorization/referrals needed to seek treatment in this office.

Unless you or your health insurance carrier has made other payment arrangements in advance, office payments are due at the time of service.
We will accept Visa, MasterCard, cash, or check.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you, if you assign the benefits to the doctor. In other words, you agree to have your insurance to pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

We have made prior arrangements with the insurers and other health plan to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/ co- insurance/deductible at the time of service.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis.
This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

All the plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialties. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

You must inform the office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

There are certain elective surgical procedures that require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to surgery.

Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees, and courts fees shall become your responsibility in addition to the balance due to this office.

There is a service fee of $ 25.00 for all returned checks. Your insurance does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____Date_____

Witness Signature: _____Date_____

OUPATIENT CLINICS
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San Mateo, CA 94401
(650) 343-7775
Fax (650) 343-3954

Half Moon Bay Clinic
725 Main Street
Half Moon Bay, CA
94019
(650) 726-4070

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Are you in ___good health ___fair health ___poor health?

Do you smoke? ___

Are you allergic to any medications? ___yes ___no

If yes, please list: _____

Are you under the care of a doctor? ___yes ___no

If yes, state reason: _____

Did you injure your foot? Yes_____ No_____ Date of injury _____

If yes, is this your first injury? Yes_____ No_____

Please describe the nature of your complaint / foot problem:

_____

_____

Where does it hurt? _____

How much does it hurt? ___doesn't ___little ___moderate ___severe

Type of pain? ___throbbing ___burning ___sharp ___dull

Does this interfere with your lifestyle? ___yes ___no

Does it prevent you from standing? ___yes ___no (How long? _____)

Does it prevent or limit wearing shoes? ___prevent ___limit

___Laced Oxford ___Slip-on ___Casual ___Pump ___Full Boot

___High Heel/Fashion Other: _____

Does it limit your physical activity? ___yes ___no

Does it prevent participation in sports? ___yes ___no

Which sports? _____