**Dr. Thomas F. Bembynista**
Diplomate, American Board Podiatric Surgery

## PATIENT INFORMATION

**First Name:** _____ **(Preferred Name):** _____
**Middle Initial:** _____ **Last Name:** _____

**Date of Birth:** ____ / ____ / _____ **Age:** _____ **Sex:** ☐ Male ☐ Female
**Marital Status:** _____ **Cell Phone #:** _____

**Home Address:**
Street _____ Apt #: _____
City _____ State _____ ZIP _____

**Email**_____
**Primary Doctor's Name & Phone #:**
_____**Date of Last Visit:** ____ / ____ / _____

Primary Reason for Visit

Heel pain -fungal nails - hammer toes - ingrown toenail- bunion- foot pain 3D Custom orthotics - Other problem_____

PAYMENT TYPE

Insurance Card (provide cards/ and driver license). Talk with insurance provider to understand coverage. OR cash payment. Dr Bembynista will discuss charges

ASSIGNMENT AND RELEASE I hereby authorize Regional Foot Centers to provide information to insurance carriers concerning my illness and treatments and to my referring physicians if requested. I hereby assign to the physician all payments for medical services rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by insurance. I authorize the use of this signature on all insurance submissions.

appt reminders opt in____ opt out _____

I understand that payment for services may be required until insurance benefits can be determined. There is a 3% fee on all credit card transactions

Signature of Responsible Party _____ Date _____ _ _____
(Parent/or Guardian if Minor)

Overland Park Office
8695 College Blvd. #220
Phone: 913-894-0660

kcfootcare.com
Fax: 913-354-7611

Green Hills Office
8530 N. Green Hills Rd.
Phone: 816-455-3636

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MEDICATION LIST ALLERGIES

_____

_____

_____

* Height, __ _____Weight _____ Shoe Size, ____ _____

*Have you Had heart grafts, or joint replacements Yes/ No

Other medical information I need to know_____

HEALTH HISTORY Insulin diabetic: __ (A1C ___ ) Rheumatoid Arthritis__ Osteoarthritis __ Hypertension__ Anemia __ _ location/on chemo/remission Cardiac disease ___ _ Liver disease __ Gout__ Neuropathy _____ Phlebitis Fainting history ___ ____ _

Any Personal concerns or fears i.e. shots or sedation_____

SURGERIES/HOSPITALIZATIONS AUTHORIZATION FOR RELEASE OF INFORMATION I hereby authorize Dr. Bembynista to use or disclose my personal health information as described below. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider. The released PHI may no longer be protected by federal privacy regulation. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice. It is available on request.

PATIENT AUTHORIZES COMMUNICATION WITH FAMILY/FRIENDS REGARDING YOUR CARE AND TEST RESULTS. NAME _____ PH _____ REL. ____ _____
PATIENT AUTHORIZES COMMUNICATION WITH FAMILY/FRIENDS REGARDING YOUR ACCOUNTING & BILLING NAME _____ PH _____ REL _____ _

PATIENT AUTHORIZES COMMUNICATION WITH PRIMARY CARE PHYSICIAN OR OTHER PHYSICIAN NAME _____
. *Signature _____ (Patient/Guardian) Date. _____ _

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# Notice of Privacy Practices and Consent Form

**Acknowledgment of Privacy Practices**

I acknowledge that I was provided with a copy of the Notice of Privacy Practices, and that I have read (or had the opportunity to read it if I so chose). I also acknowledge my understanding of the notice.

**Consent for Treatment**

I consent to such diagnostic procedures and medical care as deemed necessary by the Doctor for my treatment. I also consent to the taking of photographs, which will be used for medical education purposes.

**Financial Responsibility**

I understand that when discussing any treatment recommended by Dr. Thomas Bembynista, I am responsible for all charges. I acknowledge that my insurance may not cover certain charges for reasons including, but not limited to:

- Not bringing or not getting a referral
- Pre-certification is not obtained
- Services are not covered
- Insurance is not in effect

**Returned Checks and Collections**

I understand that there is a $40 charge for any returned check. Account balances are due within 30 days unless payment arrangements are set up with our office. Outstanding account balances are turned over to a collection agency at 60 days. A 40% fee will be added to the outstanding balance to cover collection costs.

**Insurance Filing**

Our office will file with your insurance company within 5 business days of your visit. I acknowledge that I am solely responsible for any charges my insurance company does not cover. I understand my insurance company may have co-pays, deductibles, and co-insurances.

**New Patient Policy**

New patients are required to pay for services on the first visit. This includes co-pays, deductibles, and co-insurances. These fees will be reviewed with you and are generally $200 or less. It is important that you understand what your insurance policy covers. The deductible applies to the office visits even when a co-pay is noted on the insurance card (examples would be x-rays, injections, and office surgeries).

| |
|---|
| Name of Patient (Please Print): _____ |
| Signature: _____ Date: _____ |
| Initials: _____ _____ _____ |

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