Karl E. Kado, DPM

Fellow, American College of Foot & Ankle Surgeons
Diplomate, American Board of Podiatric Surgery
Board Certified in Foot Surgery

Welcome To Our Office

Date ________________

Name____ **S.S. #**______-_____-______
(Last) (First) (M.I.)

Address______________________________________ ____________ ______ __________
(Street) (City) (State) (Zip Code)

Telephone-Home ________________ **Business**___________________**Cell** __________________

E-mail ____

Birthdate _____/_____/______ **Age**_____ **Marital Status:** (Single)(Married)(Div)(Sep)(Widowed)

Race: (Asian) (Black/African American) (Hispanic) (White) (Other: ________________________)

Ethnicity: (Hispanic/Latino)(not Hispanic/Latino)(Other) **Language:** (English)(Spanish)(Other ________)

Employer/School _________________________ **Occupation** ___________________________

Emergency/Other Contact ___________________ **Phone Number** _____________________

Pharmacy Name __________________________ **Phone Number** _____________________

Policy Holder Info: (if not same as patient)

Name _______________________ **Birthdate** ___/___/___**Relationship To Patient** _____________

Employer________________**Occupation** ______________**How Long** _____ **S.S. #**_____-____-_____

Family Physician – Dr._______________________ **Phone** ________- __________ - ____________

Please Describe Your Foot/Ankle Problems: ____

____

Patient Authorization:

- I request that payment of authorized Medicare or Insurance benefits be made either to me or on my behalf to Dr. Karl E. Kado for any services furnished me by this physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration or my insurance and its agents any information needed to determine these benefits or the benefits payable for related services.
- I authorize my insurance benefits be paid directly to the Doctor. I am financially responsible for deductible, copayments & any non-covered services.
- I give permission to the Doctor to administer treatment and perform such general procedures, as he may deem necessary in the diagnosis and/or treatment of my condition, and to also view my prescription history information.
- I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.
- I have read and agree to the above statements.

Signature ____ Date ___________________

Please Turn Page Over

Name____ Date ____________________________

PLEASE CHECK ALL THE CONDITIONS WHICH PERTAIN TO YOUR MEDICAL HISTORY

_______ Diabetes

_______ Hypertension (High Blood Pressure)

_______ Anemia/Blood Disease or Infection

_______ Mitral Valve Prolapse/Heart Murmur/Disease

_______ High Cholesterol

_______ Kidney/Liver Disease

_______ Gastric/Stomach Ulcer/Hiatal Hernia/Gastritis

_______ Emphysema/Lung Disease/Pneumonia/Asthma

_______ Seizure Disorders

_______ Painful Arthritis

_______ Wound Care Problems

_______ (Other) ____________________________

CURRENT PRESCRIPTION MEDICATIONS (and OTC Meds)

1) _________________________ **3)** _____________________________ **5)** ___________________________

2) ________________________ **4)** _____________________________ **6)** ___________________________

ALLERGIES- Medications / Latex / Foods

1)_________________**Reaction**______________ **2)** ___________________**Reaction**_______________

3) _________________**Reaction**_____________ **4)**____________________**Reaction**_______________

HOSPITALIZATIONS and SURGERIES (or Minor Foot Surgery)

____ Date _______________

____ Date _______________

____ Date _______________

____ Date _______________

Request for Confidential Communications

I request that all communications to me (by telephone, mail or otherwise) by Karl Kado Podiatry and/or its staff be handled in the following manner:

Please list the name(s) of person(s) whom we are able to speak about your conditions______________________________

____

Can we leave a message on your : Home Phone Cellphone Work Phone E-Mail None (Circle All)

Which is the best way to contact you during the day: Home Phone Cellphone Work Phone E-mail

---

How did you find out about Dr. Karl Kado? ____

____

Office Policy

Patient Name: ________________________________

I understand that it is my responsibility to know my insurance policy with regards to physician participation, required referrals, and covered services by my insurance company.

I am fully aware that it is my responsibility to provide our office with a written referral from my primary care physician if my insurance plan requires one. If I do not present a referral at the time of my office visit, I am responsible for all charges incurred.

I am aware there is a $50.00 no show fee for an appointment that is not cancelled within 48 hours of scheduled appointment time.

I understand also that confirmation of coverage, as well as an authorized referral, does not guarantee payment from my insurance company and that I will be responsible for any charges not covered by my insurance plan.

I agree to pay any co-pays and/or deductibles as per my insurance plan and that if I receive a bill from our office I am required to pay it within a thirty day period. If there is a problem with the charges I will notify our office promptly within thirty days. I understand that it is reasonable to pay balances owed prior to initiating additional treatment or evaluative services from the practice.

I hereby authorize Karl Kado Podiatry to furnish information concerning my illness and treatment to my insurance company, attorney, school, or other treating physician. I also hereby assign Karl Kado Podiatry payment for medical service rendered to myself. I understand that I am responsible for any amount not covered by insurance and that Karl Kado Podiatry requires payment at the time of treatment unless prior arrangements have been agreed upon.

____ ________________________

Signature of responsible party Date

Patient Liability Agreement

I understand that I am financially responsible for all bills incurred while under the care of Karl Kado Podiatry. In the event that my account is not paid in full, I shall be liable for any and all costs of collection. This includes, but is not limited to, all fees and costs associated with our collection agency and legal counsel. I hereby agree to be financially responsible for all such fees and costs incurred in connection with the collection of any outstanding balances I owe the practice.

I further understand that there shall be a 1.5% interest charge per month on any outstanding balance that is forwarded to collection.

By signing below, I hereby indicate that I have read and understand the terms of this contract:

____ ________________________

Signature of responsible party Date