QUALITY FOOT CARE
"Relieving Foot & Ankle Pain...
With a Personal Touch"

252 West Swamp Road #2
Doylestown, PA 18901

215-230-9707
Qualityfootcare.com

Kenneth Lefkowitz, DPM
Lonnie Kaplan, DPM

Pediatric Orthopedic Intake
Parent/Guardian Form

Thank you for choosing Quality Foot Care for the care of your children. To assist us with your visit, kindly fill out the following information.

Patient Name:______________________________Date of Birth:________________________________

Parent/Guardian Name:____

Height: ___________________ Weight: _____________________ Shoe Size: ____________________

Significant Medical History:

____

Current Medications:

____

Previous Surgeries:

____

Drug and Food Allergies:

____

Pediatrician: ____

Person who referred you (if Different from Pediatrician)____________________________________

Please describe your child's current foot and ankle issue:

____

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When did the problem start:

Is the problem getting worse?

Does the problem involve one or both sides of the body?

Is there leg or foot pain in rest and/or with certain activities?

Any current or past treatment for leg or foot pain?

Does the patient have siblings? If yes Age & Sex

Any other family members (including siblings) have a similar problem?

If yes, were there any successful treatments for them?

Any significant medical problems: including medications, trauma or surgery involving the mother during the time of the pregnancy?

Any significant issues during delivery?

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Did your child have any issues meeting any of developmental milestones at the appropriate time? (Refer to attached milestone form if needed)

____

Does your child have any issues with school, speech and learning?

____

From a parent's perspective have you ever been concerned at all with any part of your child's lower extremity/type of walk/look of feet prior to today's visit?

____

Does your child have any issues with fatigue, endurance, speed, posture, or general strength?

____

I consent to allow the doctors of Quality Foot Care to examine and treat my child whose name is listed on this form above.

Signature Parent/Guardian:_______________________________

Date:____

QUALITY FOOT CARE

WELCOME TO OUR OFFICE

Please print and complete the following information for your case history file.

Last Name	First	Middle Initial	Name preferred

Spouse's Name, Parents' or Guardian's Name if a Minor	Patient's Date of Birth	Age	Sex: ☐M ☐F

Residence Address	City	State	Zip Code

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Partnered	Social Security #

Race: ☐Amer. Indian/Alaskan ☐Pacific Islander ☐White ☐Black ☐Asian ☐Native Hawaiian	Ethnicity: ☐ Hispanic ☐ Non-Hispanic	Primary Language: ☐English ☐Spanish ☐Other: ___________

Home Phone	Cell Phone	Email

Business Phone	Name of Employer	Occupation

Preferred Method of Contact: ☐Phone ☐Mail ☐Email ☐Fax #:___________	How did you find out about our office?

Name and address of Primary Care Doctor	Phone Number

Name, address and phone of your Emergency Contact	Relationship

If other than patient, name and address of person responsible for this account	Relationship

Do you have a healthcare power of attorney? ☐ Yes ☐ No Do you have a living will? ☐ Yes ☐ No	Name of Healthcare Power of Attorney
Address and Phone Number of Healthcare Power of Attorney	Relationship

Name and Location of the Pharmacy You Use (not mail-order)

I hereby give Dr. Lefkowitz/Dr. Kaplan permission to examine and treat my feet. I authorize use of these forms on all my insurance submissions. I authorize release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize direct payment to my doctor. I permit a copy of this authorization to be used in place of the original.

Signature:____Date____________________

QUALITY FOOT CARE

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare Quality Foot Care originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Quality Foot Care reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Quality Foot Care is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already take action in reliance thereon.

I will allow the disclosure of my health information to:

Messages on my home telephone answering machine or voice mail: yes_____ no_____

Relatives: ____

Signature of patient or authorized representative ______________________

Birthdate: ____________________ Date of consent: ____________________

This practice maintains patient sign in sheets that are visible and accessible to patients, staff, and others who may enter this office...

QUALITY FOOT CARE
FINANCIAL POLICY

Thank you for choosing Quality Foot Care to serve you and your family's health needs. We are pleased to participate in your family's health care and look forward to establishing a lasting relationship as your primary health care provider. As part of this relationship, we wish to establish our expectations of your financial responsibility as outlined in our Financial Policy. **Your medical insurance is a contract between you and your insurance company. We can often help with providing information to help you in filing claims, but you are primarily responsible for any charges that you have incurred as a patient with *Quality Foot Care.*** Please review and sign the following financial policy prior to your office visit.

1) CO-PAYMENTS, DEDUCTIBLES, AND FEES — **All co-payments, insurance deductibles, and fees for services not covered by your insurance policy are due at the time service is rendered**. We accept CASH, CHECK, MONEY ORDER, or CREDIT CARDS (VISA, MASTERCARD ONLY).

2) INSURANCE — Patients must complete and sign information and insurance forms prior to seeing the physician. **You must present a current insurance card at each visit. If you or your children do not present a current insurance card, you will be responsible for payment at the time of your visit.** You will receive reimbursement from Quality Foot Care if your insurance pays the claim, at a later date. If your insurance carrier is not one with which we participate, you are responsible for payment in full. Insurance plans and Medicare considers some services to be "non-covered," in which case you are responsible for payment in full. According to NC Statute 58-22253, insurers are required to pay a properly submitted claim within 30 days. You have a responsibility to provide information to our office so a claim can be properly submitted. **If your insurance company has not paid a claim on your behalf within 90 days because of information that you have not provided, the balance will be transferred to your account and you will be responsible for payment.** If we receive payment at a later date, you will be reimbursed by Quality Foot Care.

3) MINORS AND DEPENDANTS — Parents and guardians are responsible for payments for their dependants at the time the service is rendered. **Minors and dependents must present a valid insurance card at each visit if a claim is to be filed.** See item #2 above if an insurance card is not presented.

4) MISSED APPOINTMENTS — **unless they are cancelled at least 24 hours in advance, our policy is to charge for missed appointments.** The fee for a missed appointment is $35. This fee is not covered by your insurance plan and is your responsibility.

5) PROMPT PAYMENT — Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. If you have a financial hardship or if you are unable to pay your bill in its entirety, please contact our billing office to discuss payment options. ***There will be a 1.5% late fee added per month on any account that is past due over 60 days.*** **If your account becomes delinquent and you have not established or made payment arrangements with our billing office, your account will be turned over to a collection agency. A collections fee of $75 will be added to your account in addition to the 1.5% late fee. We may ask you to seek your podiatric care from another podiatric office.**

I have read the financial policy and agree to its terms.

______________________________ Patient Signature

______________________ Date Signed