Podiatry Foot and Ankle Care, PLLC

Diplomate, American Board of Multiple Specialties in Podiatry,
Board Certified in Podiatric Surgery and Primary Care in Podiatric Medicine

Julian R. Menendez, DPM
5415 Park St. N., Suite C
St. Petersburg, FL 33709-1028
Phone: 727-544-5425 Fax: 727-544-5440

Failure to keep scheduled appointments

If you are unable to keep your scheduled appointment, we ask that you please notify our office at least 24 hours prior to your appointment time. Should you fail to provide proper notice, you will be charges $25.00 for a time that was allotted to you.

By not contacting our office to cancel or reschedule your appointment, those in need of a time slot are unfortunately unable to see us.

_____ _____

Patients/Guardian Signature Date

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

All patients must complete our Information packet and produce Insurance Cards to be copied before seeing the doctor.

CUSTOM MADE PRODUCTS (SHOES, INSERTS, ORTHOTICS, ETC.) ARE NON-REFUNDABLE

NON-INSURANCE PATIENTS (SELF PAY):

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECKS OR CREDIT CARDS
WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

INSURANCE COVERAGE:
Regarding Insurance Plans where we are NOT Providers:

We may accept assignment of insurance benefits after your second visit. However we do require 30% of the bill to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and original claim form if required. Your insurance policy is a contract between you and your insurance company. We are not a party to that contact. In the event we do accept assignment of benefits we require that you be pre-approved on our extended payment plan, pay 20% percent of the charges at the time of service or provide a credit card with authorization to bill the account for the balance. If your insurance has not paid your account in 30 days we will, on your behalf file a complaint with the Insurance Commissioner. If after the complaint has been filed, and the account is not paid in full by 45 days (from the date of service), the balance will automatically be transferred to your credit card or the extended payment plan. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other Medical Insurance.

Regarding Insurance Plans where we ARE participating providers. All co-pays and deductibles are due at the time of treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for the payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS:

Adult patents are responsible for their portion of payment at the time of service depending on Self Pay or Insurance Coverage.

MINOR PATIENTS:

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at time of service has been verified.

UNPAID BALANCES:

All accounts with unpaid balances at the end of each month will be charged an interest charge of 18%, and will continue each month until balance is paid in full.

ANY AND ALL RETURNED CHECKS WILL HAVE A $25.00 PROCESSING FEE APPLIED TO THE ACCOUNT.

Thank you for understanding Our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____

Signature of Patient or Responsible Party **Date**

AUTHORIZATION FOR
RELEASE OF CONFIDENTIAL INFORMATION

Regarding_____
Print Patient's Name

_____ _____
Social Security Number Date of Birth

NOTE TO RECEIVING PARTY: This information is disclosed to you from records whose confidentiality is protected by law. Any redisclosure is strictly prohibited without the written permission of the patient/client/legal representative identified below.

Authorize: DR. JULIAN R. MENENDEZ, D.P.M.
5415 PARK STREET N SUITE C
ST. PETERSBURG, FLORIDA 33709
(727) 544-5425 (727) 544-5440 FAX

To release written general medical information from my medical record (FL Statue 395.017) as well as psychiatric/psychological information, alcohol and/or drug information, (FL Statute 394.459) and Fed. Reg.42cFA, Part II) Human Immunodeficiency Virus (HIV) tests and other information (FL Statute 381.004) pertaining to these tests or to treatment I connection with these test results to:

_____
Name of Facility/Person Holding Information

_____
Address – City/State/Zip

_____
Phone # Including Area Code "Required"

_____ _____
Patient/Client/Legal Representative Signature Date

_____
Signature of Witness

PATIENT INFORMATION

Last Name _____ First_____
Primary Address _____
City _____ State _____ Zip_____
Home Phone _____
Cell Phone _____
Work Phone _____
Northern Address (if applicable) _____
City _____ State _____ Zip_____
Employer Name _____
Emergency Contact Name _____

Birthday
_____

Gender
____ Male
____ Female

Marital Status
___ Married
___ Single
____ Widow
____ Divorced

Social Security Number
_____

Phone _____

PRIMARY INSURANCE

Name _____
Address _____
City _____State ____ Zip _____
Phone _____
ID# _____ Group# _____
Person insured __ Self __Spouse Parent__
Insured's name if not patient _____
Person insured date of birth if not patient _____

SECONDARY INSURANCE

Name _____
Address _____
City _____ State_____ Zip _____
Phone _____
ID# _____ Group# _____
Person insured __ Self __Spouse Parent__
Insured's name if not patient _____
Person insured date of birth if not patient _____

REFERRALS

How did you first hear about Dr. Menendez?

_____

PRIMARY CARE PHYSICIAN

Physician's Name _____

Physician's Phone _____

NOTICE OF PRIVACY ACT

I have read a copy of Julian R. Menendez Notice of Privacy Practice. _____ (Initials)

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependant) have insurance coverage and assign directly to Dr Julian Menendez all Insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submission. _____ **(Initials)**

MEDICARE AND INSURANCE AUTHORIZATION

I request that payment of authorized Medicare or insurance benefits be made to me on behalf to Dr Julian Menendez for any services furnished by that physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administrator and its agent's needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other insurance" is indicated in the item 9 of the HICFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductibles, coinsurance, non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. _____ **(Initials)**

Signature _____ **Date** _____

MEDICAL HISTORY

Please circle "**Current**" or "**Past**" if you have had any of the following.

AIDS/HIV	Current	Past
Anemia	Current	Past
Bleeding Disorder	Current	Past
Cancer	Current	Past
Hemophilia	Current	Past
Swollen Neck Glands	Current	Past
Angina	Current	Past
Artificial Heart Valve	Current	Past
Chest Pain	Current	Past
Circulatory Problem	Current	Past
Heart Disease	Current	Past
High Blood Pressure	Current	Past
Low Blood Pressure	Current	Past
Rheumatic Fever	Current	Past
Stroke	Current	Past
Swelling Ankles/Feet	Current	Past
Heart Attack	Current	Past
Rheumatoid Arthritis	Current	Past
Arthritis	Current	Past
Back Problems	Current	Past
Gout	Current	Past
Asthma	Current	Past
Emphysema	Current	Past
Respiratory Disease	Current	Past
Shortness of Breath	Current	Past
Tuberculosis	Current	Past
Chemical Dependency	Current	Past
Psychiatric Care	Current	Past
Diabetes	Current	Past
Thyroid Disease	Current	Past
Eye Problems	Current	Past
Sinus Problems	Current	Past
Headaches	Current	Past
Phlebitis	Current	Past
Varicose Veins	Current	Past
Claudication (Leg cramps from walking)	Current	Past
Hepatitis	Current	Past
Jaundice	Current	Past
Liver Disease	Current	Past
Heart Burn	Current	Past
Ulcers	Current	Past
Weight Loss-unexplained	Current	Past
Numbness or tingling (in feet or legs)	Current	Past
Seizures	Current	Past
Fainting	Current	Past
Neurological Problems	Current	Past
Venereal Disease	Current	Past
Kidney Problems	Current	Past
Rash	Current	Past

ALLERGIES

___ Adhesive Tape
___ Anticoagulant Therapy
___ Aspirin
___ Codeine
___ Cortisone
___ Demerol
___ Iodine
___ Local Anesthesia
___ Novocaine
___ Penicillin
___ Seafood
___ Sulfa
___ Other _____

SURGERIES

Surgeries I have had _____
_____
_____
_____
_____
_____
_____
_____
_____

Family history of Diabetes Yes___ No____
Cancer…Yes____No____(whom)_____

PODIATRIC HISTORY

Describe the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.

_____

_____

_____

_____

_____

_____

How long?
___ Weeks ___ Months ___ Years

On a scale of 1-10 how bad is pain?
1 2 3 4 5 6 7 8 9 10
Minimal Severe

Cigarette/Tobacco use? Current Past
Years smoked? _____

How much alcohol do you consume?
___Daily ___ Weekly ___ Monthly

Have you had a flu or pneumonia vaccine?
Yes:____ No:____ Date:_____

FOOT DISORDERS

Please indicate which foot problems you Past have or had in the past.

Ankle Pain	Current	Past
Athlete's Foot	Current	Past
Bunions	Current	Past
Corns & Calluses	Current	Past
Deformed Toes	Current	Past
Fungus Nails	Current	Past
Heel Pain	Current	Past
Ingrown Toenails	Current	Past
Plantar Warts	Current	Past
Infection	Current	Past
Ulcer/Wound	Current	Past
Tired Feet	Current	Past

MEDICATIONS

Include prescriptions, over the counter medications and vitamins.

_____
_____
_____
_____

___ Listed additional meds on back.
Pharmacy Name _____
Pharmacy Phone _____

CONSENT

I certify that the above information is correct to the best of my knowledge. I give permission to Dr. Menendez to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature _____ Date _____