Kristin Blanchet, D.P.M.
12300 Alt A1A, Suite 118 Palm Beach Gardens, FL 33410
Ph no. 561-626-3338 / Fax no. 561-776-3100

Patient Name_____ Date Of Birth_____

FL Address_____City_____State____Zip_____

Out of State Address_____City_____State_____Zip_____

Primary Phone#_____Secondary Phone#_____

Last 4 of Social Security Number _____ Male_____Female_____

Email Address_____Employer Name_____

Emergency Contact Name_____Contact #_____

Family Doctor Name Printed_____

Pharmacy Name and Crossroads_____

Insurance Company Name_____

Policy Holder's name_____Date of Birth_____

How did you hear about our office?_____

Patient Name_____

What is the chief complaint for which you came to be treated? (Include foot, ankle and Leg.)
_____
_____
_____

When did it start?_____
_____
_____
_____

Other_____

Have you seen a Podiatrist before?
If Yes, Name of Dr._____
Last Visit_____
Previous Foot Problems:
_____
_____
_____

Please indicate any family history of foot/ankle problems
Please check all that apply
Ankle Pain_____
Athlete's Foot_____
Bunions_____
Corns/Calluses_____
Flat Foot_____
Numbness Foot/Leg_____
Foot/ Leg Cramps_____
Heel Pain_____
Ingrown Toenail_____
Plantar Wart_____
Swelling ankles/Feet_____
Tired Feet_____

Allergies No Allergies ____

_____Adhesive Tape
_____Aspirin
_____Codeine
_____Demerol
_____Iodine
_____Local Anesthetics
_____Novocaine
_____Penicillin
_____Other _____
_____**No Allergies**

Medications No Medications____

Please list or attach a copy of **ALL** medications with **Dosage and Strength**_____
_____
_____
_____
_____

Medical History

_____Diabetic
_____Circulatory Problems
_____Epilepsy/Seizures
_____Stroke
_____High Blood Pressure
_____Low Blood Pressure
_____Stomach Ulcers
_____Heart Disease
_____Phlebitis
_____Respiratory Disease
_____Artificial Heart valve/joints
_____Blood Clots/DVT
_____Liver Disease
_____Bleeding Disorder
_____Arthritis
_____Hypothyroidism
_____Kidney Problems
_____Gout
_____Varicose Veins
_____Glaucoma
_____Other_____

Anxiety_____
Depression_____
High Cholesterol_____
Anemia_____
Hepatitis_____
AIDS/HIV_____
Cancer-Type_____

Surgical History Please list any surgeries you have had

_____
_____
_____
_____
_____

Social History
Do you smoke?_____Amount_____Per day/Week
Are you a former smoker?_____Date you quit_____
Do you drink alcohol?_____Amount_____Per day/Week

Shoe Size_____Width_____

Height_____

Weight_____

Treatment: I give permission for Dr. Kristin Blanchet to perform general procedures in the diagnosis and/or treatment of my foot condition. I authorize payment of medical benefits of Palm City Podiatry for service provided.

Medical Records Release to Hospitals/Physicians: I, the undersigned, authorize the release of my medical information to other physicians needed to provide my care. I further authorize release to hospitals and/or healthcare facilities as pertaining to my care. I understand that my records may be faxed to hospitals and/or physicians and that all reasonable efforts will be made to maintain confidentiality.

Medical Records Release to Family: I authorize Dr. Blanchet to release information pertaining to my illness and/or treatment to_____. I authorize Dr. Blanchet to leave medical information on my answering machine. I also authorize information to be given to my spouse.

Medical Records: One copy of your medical records will be provided upon request at no charge. A pre-paid charge is required for any additional copies. There will be a charge of $1.00 per page. Please allow 10 days for copying all medical records. There is a Xray copy charge of $5.00

Patient Rights to Confidentiality: I understand that Palm City Podiatry office complies with HIPAA regulations. All medical records are confidential and cannot be disclosed without the written consent of the person to whom they pertain. I further understand that under Florida law I have the right to my medical records. I further understand that I may request that my records be released to a physician and/or medical facility: however, this request must be in writing. I understand that by law this office may only release medical records that were generated by Palm City Podiatry. We cannot release medical records from other physicians, hospital or facility. I agree to accept responsibility for a copying fee as provided by Florida statutes. I understand that employees have no responsibility or liability regarding any aspect of this authorization. Furthermore, I have the right to complain to the practice or the State of HHS if I feel that my privacy rights have been violated. It is the policy of this office that no retaliation of any type will be taken against any patient that files a complaint.

Payment of Benefits to the Physician/ Provider: I, the undersigned, understand that Dr. Kristin Blanchet has agreed to accept Medicare and/or Health Insurance for payment of my medical bills. By my signature below, I acknowledge and understand that I am fully responsible for any yearly deductible and/or coinsurance balance after Medicare or my health insurance payment which is paid to Dr. Kristin Blanchet. I understand that I am financially responsible for any charges that are not covered by my insurance plan. If I fail to give updated or current information and the claim is denied, I will be totally responsible for the entire balance. I give permission to Palm City Podiatry to release any information requested by my insurance company.

Signature_____**Date**_____

Financial Policy

Payment is Required at the time service is rendered: Please present your insurance card(s) to our office staff for photocopying and benefit eligibility verification. You will be responsible for any copay amount at the time of your visit. If you do not have insurance, 100% of the balance will be due at time of service. For your convenience, we accept MasterCard, Visa, American Express and Discover, as well as cash and checks.

In the event your check is returned for any reason, your account will be charged $25.00. In the event it is necessary for your account to be placed with an outside collection agency or attorney, you will be assessed an additional 30% of the balance to recover the collection charges.

Insurance: We file your medical insurance as a courtesy. We will warn you if we feel a service may not be covered, however, **it is ultimately your responsibility to understand your insurance benefits as to what services will or will not be covered**. If your claim is not paid within 90 days, the claim will be transferred to patient responsibility. If timely payment is not received, the amount may be referred to a collection agency or attorney.

Balances Due: Your Insurance plan is required to send you an Explanation of Benefits (EOB), which will state any balance remaining to be paid by you. At check in, your credit card information will be obtained and kept securely until your insurances have paid their portion and notified us of the balance due, if any. If your Insurance carrier assigns any additional patient responsibility amounts for deductibles, coinsurances, or non covered charges after the claim is processed; we will charge your credit card on file for this payment. If the balance due is less than $100.00 your card will be charged automatically. If the balance is greater than $100.00, we will contact you 48 hours prior to your card being charged. Should you decide to use an alternate method of payment, please alert our office within 48 hours of our contact. Our contact will include a voice message from us to you if we are unable to reach you. If your credit/debit card on file expires or otherwise becomes uncollectible, we will expect you to promptly provide a new credit/debit card.

Please bring the credit card you would like to save on file to your initial appointment

This will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment.

Authorizations: I hereby acknowledge that I have read the above policy regarding responsibility to Palm City Podiatry for medical services and treatment provided and I agree to pay Palm City Podiatry any balances unpaid by my insurance carrier for myself or the below named person.

I hereby authorize Palm City Podiatry to charge my credit card or debit card on file for the full amount owed by me for all services and/or treatment rendered by Palm City Podiatry in accordance with the terms above.

This authorization shall remain effective unless and until it is revoked by you in writing and delivered to the office of Palm City Podiatry 3131 SW Mapp Rd Palm City, FL 34990

Thank you for taking the time to review our financial policy. Your cooperation is greatly appreciated. If you have any questions, or require any assistance, we will be pleased to be of service.

I have read this financial policy and understand my rights and responsibilities.

Printed Name:_____
Email address:_____
Relationship to Patient: Self___ Spouse___ Parent___ Guardian___ Other_____
Signature (required):_____ Date:_____

Per Palm City Podiatry policy, patients who are unwilling to have a credit card on file with the practice will be required to pay an upfront deposit of $200. This deposit will be in addition to the visit copay.