PATIENT INFORMATION
DAVID W. MANSKY, DPM, PC 269-945-2222

Last Name________________________ First Name ________________________ MI ________

Address__________________________City_____________________State_____Zip_________

Email Address____

Are you interested in our patient portal? ( )Yes ( )No

Home Phone #______________________________ Cell Phone #______________________

Would you prefer appointment reminders to be a: Phone Call Text
Morning Afternoon Evening

Date of Birth____________________Age_____Gender_____SS#_________________________

Emergency Contact: Name____

Phone # __________________________ Relationship ____________________________

Ethnicity ( )Hispanic/Latin ( )Not Hispanic/Latin ( )Refused to Report

Race ( )Asian ( )Native Hawaiian ( )African American ( )Hispanic
( )White ( )Other_______________ ( )Refused to Report

Language_________________________

Release Prescription Information ( )Yes ( )No

Preferred Pharmacy name & location____

Primary Doctor__________________________

Primary Insurance: **We need the birthdate and social security number of card holder if insurance is under someone other than the patient.**

Do you have an HSA/HRA/Flex spending account? ( )Yes ( )No

Insured Name ______________________ DOB ______________ SS #______________________

DAVID W. MANSKY, D.P.M.
PATIENT'S HISTORY
(Please print and complete as fully as possible)

Date ________________

Patient Name ___________________________________ Spouse ______________________________

Guardian's name if patient is a minor____

Address if different than patient's ____

What is your foot problem? ____

When did this start? ____

Have you previous treatment such as orthotics, splints, ice, medications? ________________________

____

PLEASE ANSWER THE FOLLOWING QUESTIONS THE BEST YOU CAN

Height: __________ Weight: ___________ Shoe Size:_______________

Physician's name, address, and phone number: ____

____

Please list the medications are you presently taking:

Name:	Reason for taking:
__________________________	______________________________________
__________________________	______________________________________
__________________________	______________________________________
__________________________	______________________________________
__________________________	______________________________________

I HAVE/HAD THE FOLLOWING:(PLEASE CIRCLE ALL THAT APPLY)

Diabetes- Type:	Hepatitis	Asthma
High Cholesterol	Liver Problems	Stroke
Rheumatoid Arthitis	Kidney Problems	Gout
Blood Clots	High Blood Pressure	HIV-AIDS
Heart Attack	Poor Circulation	Cancer-Type?_______________
Heart Stents	Stomach Ulcers	Arthritis

Other: ____

(   ) I'M NOT ALLERGIC TO ANYTHING TO MY KNOWLEDGE

I'M ALLERGIC TO: (PLEASE CHECK ALL THAT APPLY)

______Aspirin ______ Lidocaine (local)

______Codeine ______Iodine

______ Penicillin ______ Sulfa

______ Adhesive/ Tape ______ Sutures

______ Latex ______ Other

Explain the type of reaction you have had to any of the above: ________________________________

____

Please list all of the surgeries and Hospitalizations you have had:

____

____

____

____

Family History: Father:__L/D__ Mother:__L/D__ Children #: Son____, Daughter_____.

Are you pregnant? ( )Yes ( )No

Do you smoke currently? ( ) Yes ( ) No If yes, how much? ________________________________

Did you smoke in the past? ( ) Yes ( ) No If yes, how much? ________________________________

If yes, when did you quit? __________________________

Do you drink alcohol? ( ) Yes ( ) No If yes, how much and how often?_________________________

Do you use illegal drugs such as marijuana, cocaine? ( ) Yes ( ) No

If yes, please explain: ____

Are you taking a blood thinner? ( ) Yes ( )No

Do you have any Prosthetic Joints/Implants/Heart Valves: __________________________

Do you require antibiotic before going to the dentist or having any procedures done? ( ) Yes ( )No

Signature of patient/guardian/parent: __________________________________ Date:____________

DAVID W. MANSKY D.P.M., PC
HIPAA/ PRIVACY PRATICES

Federal and state HIPAA laws require that after April 14th, 2003 all patients be informed of their podiatric office's particular privacy practices. We have instituted various safeguards and practices to protect your personal health information and especially focus on keeping confidential anything that you may consider sensitive information. In compliance with the HIPAA laws we are providing you with a formal notice of our privacy practices. This notice is also posted in our reception area.

In the normal process of our daily operation we do need to disclose some information about you. For instance (1) to remind you of upcoming appointments we may mail reminder cards or call and leave a message stating the time and date of your appointment, (2) to process your insurance claims we must tell your insurance company what treatment was done and date, (3) to inform you of test/lab results, (4) to send statements to you.

I request that all communication to me (by phone, mail, or otherwise) by David W. Mansky, D.P.M., P.C. is done with the following phone number and address:

PLEASE CHECK/FILL OUT:

Phone number: ( ) Home__________________ ( ) Other ___________________________
Preferred contact-**select one**: Phone call ( ) Text message ( ) Email only ( )
Best time of day to call-**select one**: Morning ( ) Afternoon ( ) Evening ( )

May we leave a message? ( )Yes ( )No

List those people we may leave a message with or speak with concerning your personal health information. ____
____

Address: ( ) Home ( ) Other ____
____
____

I have read this sheet and received (or was offered) a copy of your privacy practice.

Signature of
Patient/Guardian _______________________________________Date__________________

Print Name ____

DAVID W. MANSKY, D.P.M., PC.
AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

Name: ____ DOB:________________________

I recognize that under the health insurance portability act of 1966 (HIPAA), I may limit the scope of information that I authorize to be disclosed (released).

LIST ALL limitations you have concerning what personal health information you do not want released:
(   ) NONE

____

____

LIST ALL those people with which we are allowed to share your personal health information (ex. Spouse, parent, etc..)

____

____

Primary Care Physician: ____

This applies to all information in my medical record protected under regulation 42 in the code of federal regulations, part 2.
PLEASE CHECK ONE OF THE FOLLOWING:
__________ I approve that my entire record released.
__________ I only approve my records be released from date of service ________to date of service _____.
__________ I DO NOT approve that any of my records be released.

If deemed necessary by Dr. Mansky, I authorize this information to be sent via fax transmission.
Please sign here if you DO NOT want any information faxed ____________________________________
This release is effective until June 1st of the following year unless otherwise agreed upon. I may revoke my consent at any time by providing written consent to David W. Mansky, D.P.M., PC. I may request a copy of this authorization if I so desire.

Signature of patient/guardian____Date_________________

Revised 2/2016

No Show Policy

We value you as a patient and are invested in giving you the best care we can to help you on your path to healthy feet. Out of mutual respect for Dr. Mansky, our staff, and other patients who need appointments, we ask that you call and cancel, or reschedule, before your scheduled time (preferably 24 hours prior).

If a patient does not show up for the scheduled time and has not given prior notice, the appointment will be marked as a "No Show". All "No Show" occurrences will be noted in the electronic medical record (EMR) and the patient will be rescheduled at a date mutually agreed upon. Based on the circumstances, you may be charged a $25 fee. If a patient has three no show appointments within a year, Dr. Mansky will decide if the patient is to be dismissed from the practice.

________________________________ __________________________ ________________________

Responsible Party Signature Relationship: (self, parent, guardian) Date

Assignment and Release/Financial Responsibility

Why do I have to pay my co-pay and/or deductible? When you sign up with an insurance carrier, you are signing a contract which stipulates that you are obligated to pay your co-pay and/or deductible. That usually means you are required to pay a co-pay and/or deductible for all office visits, including follow-up exams, outpatient surgery done in our office, etc.

Why do you collect the co-pay instead of billing me like my last doctor? It is much more efficient to collect the co-pay at the time of service; otherwise it becomes more difficult and expensive to deal with administratively. It needs to be entered in the computer, bills must be mailed, and our billing person will need to track the account for payment, etc. Higher administrative costs in the office ultimately result in higher medical costs for the patient. This policy is not something we can negotiate or change.

Why can't you just "write off" my co-pay and/or deductible? There are several reasons why this is not a good idea. First, since your insurance contract stipulates that you must pay a co-pay and/or deductible, waiving this fee violates your contract. Second, when we sign up with your insurance company, we also sign a contract saying we will collect co-pays/deductibles as stipulated. Third, if the doctor gives you a discount by waiving your co-pay and/or deductible and then bills the insurance company without giving them the same discount, it could be considered insurance fraud. Thus, many medical billing consultants say that if you waive the co-pay, you cannot bill the insurance company.

I, the undersigned, certify that I (or my dependent) have insurance with ____________________________ and assign directly to DR. DAVID MANSKY, DPM all insurance benefits, if any, otherwise payable by me for services rendered. I understand that I am personally responsible for all charges that are not covered by my insurance, including, but not limited to, co-pays, deductibles and non-covered services. I further understand that I am responsible for any collection and/or legal fees incurred in the collection of any past due charges. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

________________________________ __________________________ ________________________

Responsible Party Signature Relationship: (self, parent, guardian) Date