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

Last Name_____ First Name _____ MI _____

Address_____City_____State_____Zip_____

Email Address_____

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 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 _____ Relationship_____

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

Patient Name: _____

Height: _____ Weight: _____

List ALL Medications you are presently taking; including OTC medications and reason for taking each medication:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Circle all conditions you have been diagnosed with in the past:

Alcoholism	Gout	Neuropathy
Asthma/COPD	Heart Attack	Arthritis
Blood Clots	Cardiac Stents/Heart Valves	Osteoporosis
Long term use of Blood Thinners	Hepatitis (type) _____	Hypertension
Peripheral Artery Disease (PAD)	Crohns/Colitis	High Cholesterol
Diabetes: Type 1 or 2	Hypothyroid	HIV/AIDS
Gastric Ulcers	Drop foot	Fibromyalgia
Kidney Disease/Dialysis	Stroke	Tuberculosis
Cancer (type):_____	Liver Disease	Foot Ulcers
Recent Falls		

Other medical conditions:

_____

_____

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

(Check all that apply) I am Allergic to the following:

____ Aspirin ____Codeine ____ Penicillin ____ Iodine

____ Sulfa ____ Latex ____ Sutures ____ Adhesives/Tape

____ Lidocaine (local) ____ NKDA

Other _____

List all past Surgeries and Hospitalizations:

_____ _____

_____ _____

_____ _____

_____ _____

Family History: Please check all that apply:

	Deceased	Diabetes	Heart Disease	High Blood Pressure	Cancer (type)	Other
Father						
Mother						

How many children do you have? Boys _____ Girls _____

Do you currently smoke? ( ) Yes ( ) No ( ) Former Smoker

If yes how many daily? _____

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

Consent to Treat: I certify that the information above is true and correct to the best of my knowledge. I give Dr. Mansky permission to administer and perform such procedures that may be deemed necessary for the diagnosis and/or treatment of my feet.

Signature of patient/guardian/parent: _____ Date: _____

HIPAA/ PRIVACY PRATICES/ AUTHORIZATION OF MEDICAL RELEASE

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:

Phone number: ( ) Home_____ ( ) Other _____

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

May we mail things to your home address: ( ) Yes ( ) No

Check the people we may leave a message with or speak with concerning your personal health information.

☐ Spouse_____ ☐ Other _____

☐ Primary Care Doctor _____

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

_____

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.

This release is effective one year from date of consent 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_____

PATIENT FINANCIAL AGREEMENT

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

Billing Statements: Patients will receive a billing statement after we have received payment from your insurance company. These statements are sent out monthly.

Copays/Deductibles: Patients will be responsible for any copayments or deductibles. These payments are due at the time the service. This arrangement is part of your contract with your insurance company.

- **What is a copayment**? A **copayment** is a fixed amount established by an insurance plan for sharing the cost of certain health services between the insurance plan and the insurance customer.
- **What is a deductible?** A ***deductible*** is a specific dollar amount your health insurance plan may require you to pay out of pocket toward covered *medical* care each year, before your health plan begins to pay for covered *medical* expenses.

Completion of Disability Forms: There is a $15 fee for completion of all disability forms excluding FMLA.

Custom Orthotics: If your insurance plan does not include orthotic coverage or if it is a covered benefit after deductible you will be responsible for the fee prior to orthotics being sent out.

Labs/Biopsies: Patients will be responsible for all financial payments with the third party facility that processes all labs/biopsies. This will come on a separate bill from the facility where service was rendered.

No Show Agreement: If you are unable to make your scheduled appointment please give our office a call. If you cancel your appointment within 24 hours or you do not arrive for your appointment within the 15 minute grace period given you will be charged a $25 no show fee. This is not billable to your insurance and must be paid prior to you next appointment.

Non-Covered Services: If your insurance plan does not cover a certain service due to it being an excluded benefit on your policy you will be responsible for that fee.

Non-Sufficient Funds Fee: If we receive a check that is declined for non-sufficient funds a $35 fee will be applied to your account. This is not billable to your insurance and will be your responsibility

Past Due Balances: All accounts are subject to collection proceedings after 60 days past due. All accounts must be brought current or placed on a direct withdraw payment plan to avoid collections.

Self-Pay Patients – If you do not have insurance you will be responsible for all fees associated with the service rendered at the time of service.

I understand, certify that I (or my dependent) have coverage with my insurance as present and assign directly to DAVID W. MANSKY DPM PC all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment on any balance due on my account as well as all non-covered services and over the counter products. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuation of care. I authorize the use of this signature on all insurance submissions. I acknowledge that I was offered a copy of the Notice of Privacy Practices. I also acknowledge that I have received a copy of the Patient-Provider Partnership for David W. Mansky DPM, PC.

_____ _____ _____

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

PATIENT PROVIDER AGREEMENT

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

The Patient-Provider Partnership for David W. Mansky DPM, PC

The health and wellness of our patients is a top concern at David W. Mansky DPM, PC. Providing the best possible care to every patient is our primary goal. The only way we can meet this goal is if I, your provider, and you, my patient work together. This concept is called the Patient Centered Medical Home Neighbor PCMH-N.

Our Responsibilities to You:

- Respect your privacy by not releasing treatments, discussions and records unless given permission by the patient or required by law.
- Explain diseases, treatments, and results in an easy to understand manner
- Listen to your questions and feelings to help you make decisions about your care
- Provide 24 hour access to medical care and same day appointments, whenever possible
- Provide instructions on how to meet your healthcare needs when the office is not open
- To care for you to the best of my abilities based on my understanding of current medical methods available and by staying up to date on my medical education
- Give you clear directions about medicines, surgeries, injections and other treatments
- Send you to trusted experts, if needed
- End every visit with clear instructions about expectation, treatment goals and future plans
- Communicate with your primary care doctor
- Be available to you by: patient portal, office phone Hastings (269)945-2222, Caledonia (616)891-2577, or by calling Dr. Mansky's cell phone (248)884-6280

What We Ask Of You:

- Notify our office within 48 hours if you receive podiatric related care outside of our office
- Ask questions, share your feelings and be a part of your care
- Be honest about your history, symptoms and other information important to your health
- Inform us of any changes in your health or wellbeing
- Take all your medicine and follow your provider's advice; if you're unable to do so, inform us.
- Bring in a current list of your medications to every appointment
- Make healthy decisions about your daily habits and lifestyle
- Prepare for and keep scheduled visits or reschedule visits at least 24 hours in advance whenever possible
- End every visit with a clear understanding of Dr. Mansky's expectations, treatment goals and future plans

Please note: Our office is open 9:00am to 4:30pm Monday, 9:00am to 8:00pm Tuesday, 8:00am to 4:30pm Wednesday, 1:00pm to 7:00pm Thursday, and 9:00am to 3:30pm on Friday. After hours, you may leave a message on our voice mail and we will return your call within the following business day. If you have an urgent medical issue, which cannot wait until regular office hours, you can ***call Dr. Mansky's cell phone (248-884-6280).***