KINEX PODIATRY
DIABETIC FOOT & ANKLE CLINIC

**Dr. Faiza Khan, DPM**
**Dr. Mohammad Raza Khan, DPM**
Kinex Podiatry, Foot & Ankle Clinic
P: 972-709-7556 | F: 972-709-7611

# GENERAL CONSENT FOR TREATMENT

You have the right to be informed about your condition, so that you may make the decision whether or not to undergo any of the recommended surgical, medical, or diagnostic treatments, after knowing the risks and complications involved. At this point in time, no specific treatment plan has been advised or recommended. This consent is simply to ask for your permission to conduct an evaluation necessary to determine the appropriate treatment(s) for any pertinent condition(s).

By signing below, you are indicating that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test or treatment ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a podiatrist and/or mid-level provider, such as a Medical Assistant, Nurse Practitioner, or Clinical Nurse Specialist, and other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me in to seek care at this practice.

I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient / Responsible Party Date

_____ _____

Printed Name of Patient / Responsible Party Relationship to Patient

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## AGREEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing us as your healthcare provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash (exact change only), all major credit cards, and pre-approved insurance for which our providers are **in-network**, if applicable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits, any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we are **in-network/in contract** with your insurance company, we will bill your insurance company first, minus any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we are **out-of-network/not in contract** with your insurance company, you will be expected to pay for **all services rendered** at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card **does not** confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have **out-of-network benefits** that have co-insurance changes, higher copayments, and limited annual benefits. If you receive services that are part of an out-of network benefit, your portion of financial responsibility may be higher than the in-network rate.
- **There is a NO SHOW / LATE CANCELLATION FEE of $40, if you fail to show for an appointment or fail to reschedule or cancel the appointment 24 hours prior to your appointment time.** Our staff sends email reminders and call reminders prior to your appointment date to help you avoid these charges.

Patient Statement of Agreement:

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____
Signature of Patient / Responsible Party Date

_____ _____
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## AUTHORIZATION TO PROCESS CREDIT/DEBIT CARD

I, _____, authorize Kinex Podiatry to process my credit/debit card on file to collect in absence or over the phone for services rendered, such as appointments, DME, copayments, co-insurance, balances, deductibles, orthotics/inserts, shoes, equipment rentals, etc.

I understand the Kinex Podiatry will bill my insurance company for services rendered and **I will be responsible for any dues or balances unpaid by my insurance company.**

If I am seen today as a Self-Pay patient, Kinex Podiatry will not file a claim with my insurance and I will not file for reimbursement with my insurance company either.

Name on Card: _____

Card Number: _____

Expiration Date: _____ Security Code: _____

Signature of the Card Holder: _____

Patient Name: _____ Date: _____

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## NEW PATIENT REGISTRATION

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Gender: ○ Male ○ Female SSN: _____ Email: _____

Primary Phone #: _____ ☑ Home ☑ Work ☑ Cell

Secondary Phone #: _____ ☑ Home ☑ Work ☑ Cell

Address: _____ City: _____ Zip Code: _____

Emergency Contact Name and Phone #: _____

Race: ☐ African American / Black ☐ Asian ☐ Caucasian / White ☐ Hispanic or Latino
☐ Native American / Pacific Islander ☑ Other: _____

Please indicate your preferred method of communication for appointment confirmation & reminders: ☑ Phone ☑ Email ☑ Text Message

Do we have permission to leave voice messages?: ◉ Yes ◉ No

Name of **Primary Care Provider (PCP)**: _____

PCP Address: _____

PCP Phone Number: _____ Date of Last Visit: _____

Preferred **Pharmacy**: _____ Phone: _____

Pharmacy Address: _____

Were you referred to us?

If yes, name of referring Doctor/Practice: _____

If no, how did you hear about us?: _____

**PLEASE PROVIDE YOUR DRIVER'S LICENSE AND INSURANCE CARD TO THE FRONT DESK FOR OUR RECORDS. THANK YOU.**

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## SITE OF PAIN / INJURY

Please circle the site of pain/discomfort below:

Is the pain in one foot or both feet? Please specify: ☐ Right foot only ☐Left foot only ☐ Both

How long has this been a problem?: _____

Did it start suddenly or gradually? _____

On a scale of 1 to 10, with 10 being **severe** pain, please rate your pain level: _____

How would you describe the pain/discomfort? Circle one:

☐ SHARP ☐DULL ☐THROBBING ☐ TINGLING ☐ BURNING

Other (please specify): _____

Does the pain radiate or travel? ◯ NO ◯YES If YES, where? _____

What makes the pain better? _____

What makes the pain worse? _____

What treatments have you tried so far?

_____

_____

Have you gotten any imaging done? ☐Ultrasound ☐ X-RAY ☐MRI ☐ CT SCAN

When and where did you get the imaging done? _____

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## REVIEW OF SYSTEMS

Are you **CURRENTLY** experiencing any of the following symptoms? Check all that apply:

| | | | |
|---|---|---|---|
| **General Health** | ☒ No symptoms | ☒ Weight gain/loss<br>☒ Loss of appetite | ☐ Nausea/vomiting<br>☐ Fever/chills |
| **Ears, Nose, Mouth, & Throat** | ☒ No symptoms | ☐ Difficulty hearing<br>☐ Ringing in ears | ☐ Runny nose<br>☐ Sore throat |
| **Cardiovascular** | ☒ No symptoms | ☐ Irregular heartbeat<br>☐ Chest pain | ☐ Swelling of limbs<br>☐ Numbness/weakness |
| **Respiratory** | ☒ No symptoms | ☐ Shortness of breath<br>☐ Lingering cough | ☐ Wheezing |
| **Gastrointestinal** | ☐ No symptoms | ☐ Abdominal pain<br>☐ Constipation | ☐ Diarrhea<br>☐ Blood in stool |
| **Musculoskeletal** | ☐ No symptoms | ☐ Uneven leg length<br>☐ Heel pain | ☐ Joint pain<br>☐ Joint swelling |
| **Neurological** | ☐ No symptoms | ☒ Headaches<br>☒ Dizziness | ☐ Double vision<br>☐ Tremors |
| **Integumentary (Skin & Hair)** | ☐ No symptoms | ☐ Discoloration<br>☐ Skin/nail wound | ☐ Rash<br>☐ Itching |
| **Hematologic (Blood)** | ☐ No symptoms | ☐ Excess bleeding<br>☐ Bruising easily | ☐ Anemia<br>☐ Swollen lymph nodes |

## MEDICATION LIST

☐ Not taking any medications

Please list your **current** medications in the table below. Include name of drug, dosage, and how often you take it. Inform office staff if your medication regimen changes at any time.

| NAME OF MEDICATION | DOSAGE | HOW OFTEN (DAILY, TWICE A DAY, ETC.) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

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Are you **allergic** to any **medication/food/substances**? ☐ NO KNOWN ALLERGIES ☐ YES

If YES, list the allergy **AND** reaction(s):

_____

_____

_____

Height: _____ Weight: _____ Shoe Size/Width: _____

## PERSONAL / FAMILY MEDICAL HISTORY

Please fill out the following table to the best of your knowledge.

| DISEASE / CONDITION | YOU | FAMILY MEMBER(S)? (Mother, Father, Grandparents, Siblings) |
|---|---|---|
| High blood pressure / hypertension | | |
| High cholesterol | | |
| Diabetes (specify Type 1 or Type 2) | | |
| Heart disease | | |
| Liver disease | | |
| Kidney disease | | |
| Thyroid disease (specify hyper or hypo) | | |
| Arthritis / Osteoporosis / Gout | | |
| Asthma / COPD | | |
| Immunosuppression (HIV/AIDS, lupus, etc..) | | |
| Stroke / Seizures | | |

Please list any other medical conditions **NOT** stated in the chart above:

_____

_____

**Diabetic Patients Only:**

Name of provider who is managing your diabetes (**if different from PCP named above**):

_____

Date of Last Visit: _____ Last Hg A1c: _____

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## HOSPITALIZATIONS

Please list **all** prior hospitalizations and dates of admission to the best of your knowledge.

| DATE | REASON FOR ADMISSION |
|---|---|
| | |
| | |
| | |

## SURGICAL HISTORY

Please list **all** prior surgeries and dates to the best of your knowledge.

| DATE | REASON FOR ADMISSION |
|---|---|
| | |
| | |
| | |

Any surgical complication(s)?: _____

## SOCIAL HISTORY

- Any chance you could be **pregnant**? ○ YES ○ NO
- Do you **smoke** or use **tobacco** products? ○ YES ○ NO

  How many pack(s)/day? _____ Former smokers: quit date? _____
- Do you **vape/JUUL**? ○ YES ○ NO
- Do you use **CBD or THC** products? ○ YES ○ NO
- How often do you drink **alcohol**? ☐ DAILY ☐ WEEKLY ☐ SOCIALLY ☐ NEVER
- Have you **traveled internationally** recently? ○ YES ○ NO

  Destination and travel dates: _____

  Did you ever feel sick while traveling? _____

**Acknowledgement & Consent:**
I certify that the above information is true and complete to the best of my knowledge. I give permission to **Kinex Podiatry Foot & Ankle Clinic** to administer and perform procedures deemed necessary in my diagnosis and treatment.

Patient / Parent / Guardian Signature: _____ Date: _____