Dr. Kris A. Haase 7116 Highland, Waterford, MI 48327
248-666-8807 fax 248-666-7709

Welcome to our Practice

PATIENT INFORMATION Please print clearly

Patient First Name_____ MI_____ Last Name_____
Male ❍ Female ❍ Marital Status: Single ❍ Married ❍ Widowed ❍ Separated ❍ DM ❍

Spouse/Partner Name _____ Spouse Date of Birth _____
Do you have children? Yes ❍ No ❍ Ages_____

Patient Home Street Address_____ Apt#_____

PO Mailing address [if applicable]_____

City_____ State_____ Zip _____

Patient Home Phone#[ ]_____ Cell Phone#[ ]_____

Patient email address [please print clearly] _____

Patient Date of Birth_____ Age_____ Social Security Number _____

Patient Height_____ Weight_____ Shoe Size_____
Patient Occupation_____ Employer Name_____

Employer Address_____Phone[ ]_____

BEST CONTACT INFORMATION Home Phone ❍ Cell phone ❍ Work ❍ Email ❍

If patient is a minor - provide Name of parents or guardian _____

Address of parents or guardian _____

Phone #[ ]_____ Cell phone[ ] _____

Emergency Contact Name_____Phone_____Relationship_____

PAYMENT AND INSURANCE INFORMATION- Please present your insurance card and drivers license upon arrival

Check here no health insurance ❍
Full Name of Insured _____Relationship to Patient_____

Insured SS#_____Insured Date of Birth _____

Insured Employer _____
Employer Address_____

According to my insurance, I am responsible to pay a Co-Pay Amount $_____ Deductible Amount $_____
Payment today will be made by: Cash ❍ Check ❍ Visa ❍ Master Card ❍ Discover ❍

My insurance requires a referral from my PCP before I see a specialist. Yes ❍ No ❍

REFERRAL INFORMATION *We appreciate your referrals! Who may we thank for referring you to our office?*

Name_____ Address_____
Is this person your: PCP ❍ Other Specialist ❍ Family Member ❍ Friend ❍

Other Referral Sources [check all that apply and please specify names where indicated]:

Internet Search [name]↓	Phone Book [name]↓	Our Practice Website	Newspaper Ad [name]↓	Saw our sign	Insurance Plan or Website [name]↓	Other [explain]↓

Please turn over to continue

PODIATRIC HISTORY

Have you ever been to a podiatrist before? Yes ❍ No ❍

What is your **chief foot complaint** for which you came to be treated?

_____

_____

_____

When did it begin? _____

Did you receive treatment for this condition? Yes ❍ No ❍

If so, what type?

_____

_____

Circle the **degree of pain** you are currently experiencing:

Minimal 1 2 3 4 5 6 7 8 9 10 **Severe**

Have you ever had any of the following **foot conditions**? Please check all that apply:

- ❒ Ankle Instability
- ❒ Arthritis
- ❒ Back Pain
- ❒ Blisters
- ❒ Bone Spurs
- ❒ Bunions
- ❒ Burning Feet
- ❒ Corns/Calluses
- ❒ Diabetic Evaluation
- ❒ Flat Feet
- ❒ Fracture
- ❒ Fungal Infections (skin/nail)
- ❒ Gout
- ❒ Hammertoes
- ❒ Heel Pain
- ❒ Hip Pain
- ❒ Infections
- ❒ Ingrown Toenails
- ❒ Intoe - Out toe walking
- ❒ Joint Pain
- ❒ Knee Pain
- ❒ Limb Length Discrepancy
- ❒ Neuromas
- ❒ Numbness or tingling in foot or toes
- ❒ Plantar Fasciitis
- ❒ Postural Fatigue
- ❒ Pronation
- ❒ Shin Splints
- ❒ Sprains
- ❒ Sweating/Odor
- ❒ Tendonitis
- ❒ Tired feet
- ❒ Ulcers
- ❒ Warts

MEDICAL HISTORY

Have you ever been treated for any of the following conditions? Please ✓ all that apply to you;
Put an **M** if on your mother's side;
Put an **F** if on your father's side

- _____Acid Reflux
- _____Anemia
- _____Arthritis
- _____Asthma
- _____Bleeding Disorders
- _____Cancer
- _____Depression
- _____Diabetes
- _____Epilepsy
- _____Fatigue
- _____Fibromyalgia
- _____Headaches
- _____Heart Condition
- _____Hepatitis
- _____High Cholesterol
- _____HIV/Aids
- _____Hypertension
- _____Hyperthyroidism
- _____Hypothyroidism
- _____Irritable Bowel Syndrome
- _____Kidney Problems
- _____Liver Disease
- _____Low Blood Pressure
- _____Nervous Disorder
- _____Muscle or Joint Pain
- _____Peripheral Arterial Disease
- _____Parkinson's Disease
- _____Phlebitis
- _____Poor Circulation
- _____Respiratory Disease
- _____Rheumatic Fever
- _____Shortness of Breath
- _____Seizure Disorders
- _____Stomach Ulcers
- _____Stroke
- _____Varicose veins

MEDICATIONS

Are you currently on Blood Thinners? Yes ❍ No ❍

You can provide a printed list of your medications or list them below:

Name of Medication	Strength/Mg	Take how often?

Do you currently use: Cigarettes or Tobacco? Yes ❍ No ❍ Quit ❍

If yes, for how long? _____How many pks/day?_____

If quit, when? _____yrs _____months

Alcohol use? Yes ❍ No ❍ If yes, quantity _____daily _____weekly

SURGERIES

Please list all surgeries	Approximate Date

Name of MD/Family Physician _____

Address _____

Date of Last Visit _____

ALLERGIES

Have you ever had any adverse side effects or allergies to:	YES	NO		YES	NO
Adhesive Tape			Metal/Jewelry		
Anticoagulants			Novacaine		
Anti-inflammatory Meds			Peanuts		
Aspirin			Penicillin		
Codeine			Seafood		
Cortisone			Other antibiotics		
Iodine			Other pain medication		
Latex			Other		

If other, please explain _____

SIGNATURE ON FILE AND PERMISSION TO TREAT

- ♦I understand that the information provided on this form is true and correct to the best of my knowledge.
- ♦I request that payments of authorized benefits be made on my behalf for any services furnished by Kris A. Haase, D.P.M.
- ♦I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent.
- ♦I recognize my financial obligation of any coinsurance, co-pays or deductibles and non-covered services that may be required.
- ♦I hereby give permission to Kris A. Haase, D.P.M. and any qualified staff to evaluate, diagnose and treat my foot and/or ankle condition as may be deemed necessary.

Patient or Authorized Signature√_____

If not patient, state relationship _____Date _____

Financial Policy

Payment Policy

Thank you for choosing Kris A. Haase, D.P.M. as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become non refundable if the proper referral is not obtained by then.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 60 days past due, you will receive a letter requesting immediate payment. A $10.00 rebilling fee will be charged for each additional invoice sent out after 30 days. Partial payments will not be accepted unless otherwise approved by our Billing Department. Please be aware that if a balance remains unpaid, we may refer your account to small claims court and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge $25.00 for missed appointments not canceled within a reasonable amount time or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

9. Forms and Documents. It is our policy to charge $10.00 for completion of all forms, such as disability applications, etc.

10. Fees. Our fees are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

v_____ _____

Signature of patient or responsible party Date

Privacy Statement

The office of Kris A. Haase, D.P.M. will use and disclose your health information for the following purposes: to treat you, to assist other healthcare provides in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you have any questions, concerns or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices provided to you for the person(s) whom you may contact.

Additional Disclosure Authority:

In addition to the allowable disclosures described in the State of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Please circle your choice(s) below:

Any member of my immediate family	YES	NO
Spouse Only	YES	NO
Other (Please specify)	YES	NO

Acknowledgement of Receipt of Notice of Privacy Practices:

(Signature represents that I have been offered a copy of the policy)

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understood the Notice.

v_____ _____

Signature Date

_____

Patient Name or Authorized Representative (Print)