Foot & Ankle Specialists of Southeast Michigan

Medicine and Surgery of the Foot & Ankle

Charles G. Kissel, D.P.M.
Brian Kissel, D.P.M.
Erik Kissel, D.P.M.

Jeffrey Danto, D.P.M.
Robert Rubin, D.P.M.
Aimee Popofski, D.P.M.

WELCOME TO OUR OFFICE

NAME:_____BIRTHDATE:_____/_____/_____SEX: ☐ MALE ☐FEMALE

SOCIAL SECURITY #: XXX-XX-_____ RACE:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

PHONE:HOME:(_____)_____CELL:(_____)_____OTHER:(_____)_____

EMAIL: _____

MARITAL STATUS: ☐SINGLE ☐ MARRIED ☐WIDOW ☐DIVORCED ☐SEPARATED

EMERGENCY CONTACT NAME:_____ RELATION:_____
EMERGENCY CONTACT PHONE: (____) _____

PRIMARY INSURANCE: _____ ID NUMBER:_____

SUBSCRIBER'S NAME:_____ SUBSCRIBER'S BIRTHDATE:_____/_____/_____

SECONDARY INSURANCE: _____ ID NUMBER:_____

SUBSCRIBER'S NAME:_____ SUBSCRIBER'S BIRTHDATE:_____/_____/_____

EMPLOYMENT STATUS: ☐ PART TIME ☐ FULL TIME ☐STUDENT ☐ RETIRED ☐OTHER
EMPLOYER NAME / COMPANY: _____ PHONE:_____

IS THIS INJURY RELATED TO A WORKERS COMPENSATION CLAIM OR AUTO ACCIDENT?

IF YES: ☐WORKERS COMPENSATION ☐AUTO INSURANCE COMPANY: _____
CLAIM NO.:_____DATE OF INJURY: _____/_____/_____

PHARMACY INFORMATION:PHARMACY NAME: _____

ADDRESS/CROSS ROADS:_____ CITY:_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

I HAVE READ, UNDERSTAND AND AGREE TO THE OFFICE & FINANCIAL POLICIES PROVIDED TO ME WITHIN THIS PACKET. I HEREBY ATTEST THAT I AGREE TO PROVIDE CURRENT DEMOGRAPHIC AND INSURANCE INFORMATION AND AUTHORIZE RELEASE OF INFORMATION NECESSARY FOR INSURANCE FILING AND PRE-CERTIFICATION BY SIGNING THIS STATEMENT.

A COPY OF THE OFFICE & FINANCIAL POLICIES CAN BE REQUESTED AT THE FRONT DESK.

PATIENT SIGNATURE:_____ DATE:_____

Foot & Ankle Specialists of Southeast Michigan

OFFICE & FINANCIAL POLICY

Insurance/Referrals

You are responsible for knowing your insurance benefits and coverage and whether a referral is needed for specialist visits. You are responsible to pay all balances, co-pays, deductibles, and non-covered services at the time of your visit, unless prior arrangements have been made. We will submit your bills to your insurance company for you directly unless you request otherwise. We accept cash, money orders, checks, Visa, MasterCard, and Discover. It is the patient's responsibility to obtain all insurance referrals from their primary care physician as required by their insurance company. Patients will be asked to reschedule their appointment if proper documentation is not provided upon check in.

Statements

If you have an unpaid balance a statement will be mailed to you monthly to reflect any unpaid balances as well as balances transferred to you (co-pays and deductibles) as determined by your insurance company after they have made their payments. Claims can take *several* months to finalize. No statement will be mailed out for less than $5.00 but the balance will remain the patient's responsibility. Payment is expected upon receipt of your statement. If there are questions regarding the balance, or if you cannot pay your balance, please call our office and speak to our billing staff immediately, so our staff can assist you in making payment arrangements. **If no payment is made within 90 days, your account may be referred to an outside collection company with instructions to enforce collection of your account.**

Self-Pay Patients

New patients presenting without insurance are required to pre-pay a deposit of $100.00. Once seen and services rendered, the balance of payment due for that date of service is expected to be paid prior to leaving the office.

Check-In/ Check-Out

Bring your current insurance card with you on EACH VISIT. Without the insurance card we will be unable to file your insurance claim and you will be responsible for the charges for that day. Please be prepared to pay for the current visit for any co pays, deductibles or fees for non-covered services.

Late Arrivals

If you arrive more than 15 minutes past your scheduled appointment time you may be rescheduled so that other patients are not inconvenienced.

Telephone Communications

I give my permission to Foot & Ankle Specialist of Southeast Michigan to contact me for any purpose at the current or any future numbers that are provided for my landline telephone, cellular telephone or any wireless device including the use of automated dialing equipment, prerecorded voice or text message. I also give permission to receive emails as needed.

Medicare patients only

The coverage of Medicare part B is as follows: Each calendar year (beginning January 1 and ending December 31st) a Medicare beneficiary must satisfy a deductible of $185.00 for covered services based on physician's reasonable charges. Medicare will assume liability for paying 80 percent of the reasonable charges for covered services during the remainder of that year. The deductible plus 20 percent (referred to as coinsurance) is the beneficiary's responsibility. This may or may not be paid by the patient's secondary insurance coverage. On January 1 of each year the patient becomes responsible for a new deductible.

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Discrimination

Discrimination is against the Law. Foot & Ankle Specialists of Southeast Michigan complies with all applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

PCMH

Foot & Ankle Specialists of Southeast Michigan participates in the Patient Centered Medical Home (PCMH). PCMH is a concept where patients take an active role in their health care, working closely with their PCP & Specialist to navigate through the health care system.

Release to treat

I hereby give permission to: Dr. Charles Kissel, Dr. Erik Kissel, Dr. Brian Kissel, Dr. Aimee Popofski, Dr. Jeffery Danto,Dr. Robert Rubin and Lena Antoski N.P. or any designated person to examine and treat my feet as necessary, today and on any future dates. In addition, I give permission to video tape and/or audio tape (i.e., record) any material and/or information which the doctor deems necessary for his/her records.

Release to insurance

I hereby assign all medical benefits including major medical benefits to which I am entitled including Medicare, private insurance and any other health plan to any provider at Foot & Ankle Specialists of Southeast Michigan. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignees to release all information necessary to secure payment.

Authorization to E-Prescribe medications

To enhance our patient's convenience, we have the ability to send specific prescriptions electronically to the pharmacy of the patient's choice. Please be aware that not all medications can be prescribed electronically due to DEA rules and regulations.

You may request a copy of our Office & Financial Policy at the front desk.

PATIENT HISTORY

NAME:_____BIRTHDATE:_____/_____/_____ XRAY#:_____
(OFFICE USE ONLY)

REASON FOR YOUR VISIT: _____

PAIN LEVEL:

PRIMARY CARE PHYSICIAN:

PHYSICIAN FIRST & LAST NAME: _____ DATE LAST SEEN: ___/___/___
CITY OF PRIMARY CARE PHYSICIAN: _____

DIABETIC INFORMATION:

ARE YOU DIABETIC? ☐YES ☐NO

IF YES :TYPE: ☐ TYPE I ☐TYPE II LAST A1C:_____ LAST BLOOD SUGAR: _____
DIABETES DOCTOR INFORMATION
FIRST & LAST NAME: _____ DATE LAST SEEN: ___/_____/____ CITY:_____

ALLERGIES:
_____
_____

MEDICATIONS (INCLUDING OVER THE COUNTER):
_____
_____

CURRENT HEIGHT:_____ CURRENT WEIGHT: _____

IMMUNIZATIONS:

INFLUENZA ☐DATE:_____

PNEUMONIA ☐DATE:_____

SOCIAL HISTORY:(Check all that apply)

DO YOU CONSUME BEER, WINE, OR LIQUOR? ☐YES☐NO HOW OFTEN? ☐SOCIAL ☐ DAILY

DO YOU USE NICOTINE? ☐YES ☐NO ☐ FORMER SMOKER HOW MANY YEARS? _____

FAMILY HISTORY:

ARE ANY IMMEDIATE FAMILY MEMBERS DIABETIC? ☐ YES ☐ NO

☐ PLEASE INFORM OUR MEDICAL STAFF IF YOU ARE PREGNANT OR NURSING AT THIS TIME.

MEDICAL HISTORY: PLEASE CHECK ALL THAT APPLY

NEUROLOGICAL/ PSYCHIATRIC

		(OFFICE USE ONLY)
ANXIETY		F419
DEPRESSION		Z8659
BIPOLAR		F3160
DEMENTIA		F0280
EPILEPSY/SEIZURS		G4089

HEMATOLOGIC DISORDERS

ANEMIA		D598
BLOOD CLOTS		I82509
PULMONARY EMBOLISM		I2699
IMMUNE DISORDER		D899
SICKLE CELL ANEMIA		D5780

CARDIOVASCULAR & CIRCULATORY

HEART DISEASE		I519
CORONARY ARTERY DISEASE		I519
CONGESTIVE HEART FAILURE		I5040
A FIB (ATRIAL FIBRILLATION)		I482
VEIN/ ARTERY DISEASE (LEGS)		I7389
HIGH BLOOD PRESSURE		I10
PACEMAKER		Z95811
HEART ATTACK		I252
STROKE / CVA		I639

RESPIRATORY

CHRONIC BRONCHITIS		J42
ASTHMA		J45909
COPD		J449

GASTROINTESTINAL

		(OFFICE USE ONLY)
STOMACH ULCER		K219
ACID REFLUX		K219
CROHNS DISEASE		K50919

ENDOCRINE

HIGH CHOLESTEROL		E785
OVERWEIGHT		E6601
DIABETES		E138
THYROID DISORDER		E0789

GENITOURINARY

KIDNEY DISEASE ON DIALYSIS		N189
KIDNEY STONE		N209

SKIN&NAILS

NAIL FUNGUS		B351
THICK NAILS		Q845
KELOID SCAR		L910
DERMATITIS		L989
ULCER FEET/LEGS		L97909

MUSCULOSKELETAL

BACK PAIN		M545
ARTHRITS		M1380
RHEUMATOID ARTHRITIS		D899
GOUT		M109
AMPUTATION		S88929D

GENERAL

MULTIPLE SCLEROSIS		G35
CANCER		C801
COMPLICATIONS WITH ANESTHESIA		T8859
HIV/AIDS		B20
HEPATITIS / LIVER DISEASE		B188

ANY RELEVANT SURGERIES:

_____

_____

_____

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OFFICE LOCATIONS

WARREN
29433 Ryan Road
Warren, MI 48092
P: (586) 574-0500
F: (586) 574-2694

TROY-STERLING HEIGHTS
43200 Dequindre Road
Suite 102
Sterling Heights, MI 48314
P: (586) 997-5000
F: (586) 997-5009

LIVONIA
15873 Middlebelt
Suite 400
Livonia, MI 48154
P: (734) 425-0060
F: (734) 425-0453

DETROIT-FISHER BUILDING
3011 W. Grand Blvd.
Suite 874
Detroit, MI 48202
P: (313) 874-3232
F: (313) 872-4522

NORTHPOINTE
27901 Woodward Ave.
Suite 110
Berkley, MI 48072
P: (248) 545-0100
F: (248) 545-1285

WWW.FOOTANDANKLESEMI.COM