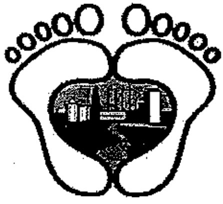


Kansas City Institute of Podiatry

JEFFREY T. ROITH, DPM
SARAH E. RUSSELL, DPM
JASON W. BURKLE, DPM

PHONE 913-894-4040
FAX 913-438-4725

PLEASE PRINT AND COMPLETE ALL INFORMATION

PATIENT INFORMATION

Patient Name (Last, First, Initial)				Home Phone	Cell Phone
Address	Social Security #	DOB	Age	☐Male ☐Female	Marital Status M S D W
City, State, Zip				Email Address	
Employer	Phone #	Primary Care Physician (PCP)			PCP's Phone #
Occupation	Business Address	City, State, Zip			

GUARANTOR INFORMATION (Insurance card holder, parent info if patient is a minor, or person responsible for account)

Name	Relationship	Phone #
Address		Social Security #
City, State, Zip		Occupation
Employer		Phone #
Business Address		City, State, Zip

EMERGENCY CONTACT

Contact's Name	Relationship to Patient
Home Phone ( )	Work Phone ( )

INSURANCE INFORMATION (We will also need a copy of your insurance card)

Primary Insurance Company	Name of Insured	Date of Birth	Relationship to Patient
ID #	Group #	SSN of Insured	
Secondary Insurance Company	Name of Insured	Date of Birth	Relationship to Patient
ID #	Group #	SSN of Insured	

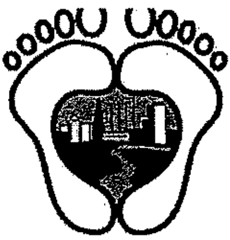
HOW DID YOU BECOME AWARE OF OUR SERVICE?

Referred By:________________________ ☐ Ins Co ☐Yellowbook ☐Yellow Pages ☐Website ☐Lifetime Fitness

CONSENT FOR TREATMENT AND FINANCIAL ARRANGEMENTS

I, the undersigned, certify that I (or my dependent) have coverage with the above insurance company and assign directly to Jeffrey T. Roith, DPM and/ or Sarah E. Russell, DPM and/or Jason W. Burkle DPM all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient or Responsible Party Signature	If Not Patient - Relationship	Date



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THIS FORM IS ABOUT PERMISSION TO SPEAK WITH ANOTHER PARTY REGARDING REMINDER CALLS, MEDICAL RECORDS, BILLING RECORDS, AND NOTICE OF PATIENT CARE UTILIZING PHOTOGRAPHY.

Patient's Name: ______________________________ DOB: ______________

REMINDER CALLS:

☐**Home:** Leave message
- ☐ on answering machine
- ☐ with anyone who answers home phone
- ☐ only with ________________(Name)
- ☐ contact patient only

☐**Office:** Leave message
- ☐on voice mail at work
- ☐with anyone who answers work phone
- ☐only with ______________(Name)
- ☐contact patient only

☐**Other:** ______________________ Phone ______________

MEDICAL RECORDS:

I hereby authorize you to discuss my medical treatment with:

______________________ Phone ______________
(Person or Party you are permitting to receive information)

______________________ Phone ______________
(Person or Party you are permitting to receive information)

______________________ Phone ______________
(Person or Party you are permitting to receive information)

☐**DO NOT RELEASE OR DISCUSS MEDICAL TREATMENT WITH ANYONE OTHER THAN PATIENT AND/ OR RESPONSIBLE PARTY.**

ACCOUNT INFORMATION

I hereby give permission for the following individuals to discuss my billing/account information:

______________________ Phone ______________
(Person or Party you are permitting to receive information)

______________________ Phone ______________
(Person or Party you are permitting to receive information)

______________________ Phone ______________
(Person or Party you are permitting to receive information)

☐**DO NOT RELEASE OR DISCUSS BILLING/ACCOUNT INFORMATION WITH ANYONE OTHER THAN PATIENT AND/ OR RESPONSIBLE PARTY.**

PHOTOGRAPHY DOCUMENTATION

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Jeffrey T. Roith, Sarah E. Russell, and Jason W. Burkle will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law as outlined in Kansas City Institute of Podiatry's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative. This consent does not authorize the use of other images for other purposes, such as teaching or publicity. A separate consent for photography form should be used for such purposes.

______________________________ ______________
Signature of Patient or Responsible Party Date

Kansas City Institute of Podiatry

JEFFREY T. ROITH, DPM
SARAH E. RUSSELL, DPM
JASON W. BURKLE, DPM

OFFICE FINANCIAL POLICY

This sheet has been prepared for your benefit. It contains information regarding our billing and insurance procedures. If you have any questions regarding the following policies, please feel free to talk to us about them.

Our office operates on a fee for services basis. All co-pays are due at the time of service. We will file all insurance claims. If we are not contracted with your insurance company, all charges including examination, consultation, x-rays and special tests performed in the office are due and payable in full at the time of service. We will accept cash, personal checks, money orders, MasterCard, Visa, and Discover. If other arrangements are necessary please discuss them with our office manager **BEFORE** you see the doctor.

Payment of the doctor's fee is the personal financial obligation of the patient or the person authorizing treatment. This personal obligation is not altered because the patient's charge is covered, in whole or in part, by insurance. **It is your responsibility to know what is and is not covered by your insurance company. It is your responsibility to know whether or not the doctor you are seeing is contracted under your plan.** Full payment is expected within 30 days. Any statement not receiving a payment after 30 days is past due. There will be a $10 monthly late fee and all balances will be assessed a 1% monthly late charge each month on all balances that are not paid within 30 days. There is a $30 fee for any check that is returned for insufficient funds. For those patients requiring a referral from their primary physician, as requested by your insurance company…**please note**…it is **YOUR** responsibility to obtain these before coming in for an office visit and/or surgery. Thank you for your cooperation.

I authorize the release of any medical or other information to my insurance company as they request. I agree that a photographic copy of the authorization is a valid as the original.

I hereby authorize payment of medical benefits directly to **Kansas City Institute of Podiatry, Jeffrey T. Roith, DPM** and/or **Sarah E. Russell, DPM** and/or **Jason W. Burkle DPM** for the services described on the attached claim form.

I understand that regardless of performance by my insurance company I am responsible for payment of my account. In the event that I should default or my account should become seriously delinquent, I agree to pay all reasonable collection costs including but not limited to attorney fees, agency fees, court costs, and the like.

I, ______________________________, have read the above financial policy and understand my obligation.
Patient's Name (Printed)

Signature:_____________________________________ Date ___________________________

OUR POLICY REGARDING RELEASE OF PROTECTED HEALTH INFORMATION

We are more than happy to forward a copy of your medical records to another physician per your request. You must complete an Authorization For Disclosure of Protected Health Information form (available in our office), and a fee may be charged for handling and reproduction. No original X-rays will be released per HIPAA guidelines. However, a quality digital reproduction will be made available upon request. Please provide a reasonable amount of time for copying.

I have read the above release of information policy and understand its content.

Signature: ____________________________________ Date ___________________________

Kansas City Institute of Podiatry
Jeffrey T. Roith, DPM
Sarah E. Russell, DPM
Jason W. Burkle, DPM
10550 Quivira Road, Suite 360
Overland Park, KS 66215
Phone: 913.894.4040 Fax: 913.438.4725

Please answer the following questions in order to complete your health record, as required by CMS:

What is your primary language? ______________________________

What is your race?
____American Indian
____Asian
____Black or African American
____Native Hawaiian or Other Pacific Islander
____White

What is your ethnicity?
____Hispanic or Latino
____Not Hispanic or Latino

Have you had a flu shot this season? ____Yes ____No

Please answer only if you are over 65 years old:

Have you ever had the Pneumonia Vaccine? ____Yes ____No

Please answer only if you are diabetic:

What was your last A1C? _______

Printed name: ______________________________

Signature: ______________________________

Date of Birth: ____________________ Today's Date: ____________________

Revised 1-2-19

Kansas City Institute of Podiatry

Dr. Jeffrey Roith, Dr. Sarah Russell & Dr. Jason Burkle
10550 Quivira Road, Suite 360
Overland Park, KS 66215

Name: ______________________ Date of Birth: ______________

Primary Care Physician: ______________________ Date Last Seen: ______________

Height: __________ Weight: __________ Shoe Size: __________

Chief Concern

Reason for today's visit? ______________________

Is your current problem due to an injury? If so, when and where? ______________________

How long has this problem been present? ______________________

From 1 to 10 what is the level of your pain? (1 is low, 10 is high) ______________________

Does anything improve this problem? ______________________

Does anything worsen this problem? ______________________

What treatments have your tried? ______________________

Have you seen a podiatrist or other physician for this problem? ______________________

Have you seen a podiatrist for any other problems? If so, what? ______________________

Medical History

Please CHECK any current or past conditions

___ Alcoholism
___ Anemia
___ Anorexia
___ Appendicitis
___ Arthritis
___ Asthma
___ Bleeding Disorder
___ Bronchitis
___ Cancer
___ Cataracts
___ Chemical Dependency
___ Chicken Pox
___ CHF
___ Coronary Disease
___ COPD
___ Dementia
___ Diabetes
___ Emphysema
___ Epilepsy
___ Gout
___ Heart Attack
___ Heart Disease
___ Hepatitis
___ Hernia
___ High Blood Pressure
___ High Cholesterol
___ HIV/AIDS
___ Kidney Disease
___ Liver Disease
___ Measles
___ Migraines
___ Miscarriage
___ Mononucleosis
___ Multiple Sclerosis
___ Mumps
___ Pacemaker
___ Pneumonia
___ Polio
___ Prostate Problem
___ Psychiatric Care
___ Rheumatic Fever
___ Scarlet Fever
___ Seizures
___ Stroke
___ Suicide Attempt
___ Thyroid Problems
___ Tonsillitis
___ Tuberculosis
___ Typhoid Fever
___ Ulcers
___ Other______________________

Medication List

Please list ALL medications: Prescribed, Over-the-Counter, Vitamins and/or Supplements OR attach medication list

Medication Name	Dosage	Frequency

Allergies/Sensitivities

Please list ALL allergies/sensitivities and reaction to each

Allergy To	Reaction

Surgical History & Hospitalizations

Year	Procedure and/or Reason

Social History

Please CIRCLE and/or ANSWER what applies to you

I am....... SINGLE MARRIED WIDOWED SEPARATED DIVORCED

I live with ______________________________

Smoker? CURRENT, I smoke ____ pack(s) per day
FORMER, I quit______ years ago
NEVER

Do you drink alcohol? YES, I have ______drinks per week
NO

Do you drink caffeine? YES, I have ______drinks per day
NO

Do you use any recreational drugs? YES NO

Are you currently employed? YES NO

Do you have children? YES, I have ______ children
NO

Are you currently pregnant? YES NO

Family History

Does anyone in your family have history of the following? If YES, check and list who (Mother, Father, Siblings, Children)

___ Arthritis:______________ ___COPD:____________ ___Heart Attack:______________ ___Mental Illness:_____________

___Asthma:______________ ___Diabetes:____________ ___Heart Disease:______________ ___Stroke:_________________

___Cancer:______________ ___Glaucoma:____________ ___High Blood Pressure:____________ ___Tuberculosis:______________

___Chemical Dependency: ___Gout:______________ ___Kidney Disease:______________ ___Other:_________________

____

Review of Systems

Please CHECK any symptom you *have currently or had within the past year*

Constitutional
__Recent Fevers/Sweats

Cardiovascular
__Blood Clots
__Poor Circulation
__Swelling of Ankles
__Varicose Veins
__Venous Insufficiency

Endocrine
__Cuts take longer to heal
__Extreme Thirst
__Hyperglycemia
__Hypoglycemia

Neurological
__Neuropathy

Allergic/Immunologic
__Gouty Attack

Psychiatric
__Depression

Musculoskeletal
__Arthritis
__Fracture:____________
__Joint Pain:____________

Skin
__Bruise Easily
__Cellulitis
__Chronic Wounds
__Itching
__Rash

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: ______________________________________ Date: ________________