ANTHONY SIKOUTRIS, D.P.M.

Central Missouri Podiatry, Inc.
1701 S. Lafayette Ave., Sedalia, MO 65301
(660) 827-6311 Fax: (660) 827-5183

PATIENT REGISTRATION

(Please print clearly or circle)

Patient's Full Name as on Insurance card: ____________________

Age: _____ **Date of Birth:** ____________ **Sex:** Male Female **Marital Status:** Single Married Divorced Widowed

Ethnicity: Non-Hispanic Hispanic **Preferred Language:** English Spanish Other: ____________

Race: White African American Asian Pacific Islander American Indian Unknown Decline to Say

Mailing Address: ____________________
Street City State Zip

Social Security Number: ____________ **Cell Phone:** ____________

EMAIL: ____________ **Home Phone:** ____________

Place of Employment: ____________ **Work Phone:** ____________

Spouse or Guardian: ____________ **Employed by:** ____________

Home Phone: ____________ **Cell Phone:** ____________ **Work Phone:** ____________

Social Security Number: ____________ **Date of Birth:** ____________

Patient's Family Doctor: ____________ **Date of Last Visit:** ____________

Who referred you to, or how did you hear of, Dr. Sikoutris? ____________

☐ Doctor ☐ Phonebook ☐ Internet ☐ Friend ☐ Family

In case of an emergency, please list the name, address, and telephone number of a person who does not live at your address that we may contact: ____________________

____________________ What is your relationship: ____________

INSURANCE INFORMATION

Primary Insurance: ____________ I.D. or Policy #: ____________

Policy holder Name: ____________ Date of birth: ____________ Copay: ________

Secondary Insurance: ____________ I.D. or Policy #: ____________

Policy holder Name: ____________ Date of birth: ____________ Copay: ________

PLEASE NOTE: PATIENT OR GUARDIAN IS RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE.

AUTHORIZATION

I hereby authorize Anthony Sikoutris, D.P.M. to furnish the necessary information to my insurance carrier(s) and referring physician concerning my diagnosis and treatment. I certify that the above information is true, accurate, and complete. I also authorize, where applicable, that my insurance benefits be paid directly to Anthony Sikoutris, D.P.M. in care of Central Missouri Podiatry, Inc. I understand that I am financially responsible for all charges accrued.

____

Signature of Patient or Guardian Date of Signature

Name: ____________________ Weight: ______________ Height: ________________

Social and Preventive History

Do you currently smoke or chew tobacco? □Yes □No If no, have you in the past? □Yes □No

Family History

List any serious illness

Mother ________________

Father ________________

Additional Patient History

Did you have FLU shot? YES NO If no, Declined, Allergic, or Unavailable

Do you have a Living Will? YES NO

Have you had a Pneumonia Vaccination? YES NO

Please list all **drug allergies** and the reaction you had: ________________________________

Please list **all current medications** with dosage and how often you are taking them. Please include all non-prescription drugs. ________________________________

***What is your preferred pharmacy AND city it is in? ________________________________

Do you have a history of:

☐ Diabetes A1c______ Date last Vist __________	☐ Lung Problems
☐ Peripheral Vascular Disease (PVD)	☐ Asthma
☐ Fibromyalgia	☐ Peripheral Neuropathy (PN)
☐ Lower Back Pain	☐ Liver Disease
☐ High Blood Pressure	☐ Thyroid Disease
☐ High Cholesterol	☐ Hepatitis
☐ Heart Problems, Heart Attack ____Yes _____ No ☐ Do you have a Pace Maker ____Yes ____No	☐ Are you HIV positive? ______ Yes _______ No
☐ Arthritis	☐ History of Foot Ulcers

History of any other medical problems not listed? ________________________________

Have you or a family member ever had a reaction to a local or general anesthetic? ________________

Please list all major and minor **operations** you have had: ________________________________

What is your main concern or complaint that you would like Dr. Sikoutris to address? ________________

What size shoe do you wear? ________________

Have you ever seen a Podiatrist before? ____________________ If so, when? ______________

Location: ________________________Treatment rendered: ______________

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I have been informed by Central Missouri Podiatry, Inc. that the "Notice of Information Practices" is available in their waiting room for review. I understand that I have the right to ask questions in order to seek clarification and/or request a copy of this document.

****ATTENTION** OUR PRIVACY NOTICE IS ON THE WALL BY THE DESK**

Any medical or billing information may be discussed with the following:

____
Name (s)
____

______________________ ______________________
Patient Signature Date

____
Parent or Authorized Representative (if applicable)

AUTHORIZATION OF OFFICE AND PAYMENT POLICY

I have read and understand the office policies regarding updating my information, payment contracts, insurance filing, co-pays, and collections. I have also been given a copy of the policies.

______________________________ ______________
Signature of the Patient or Guardian Date

Central Missouri Podiatry, Inc.
SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. 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.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

CENTRAL MISSOURI PODIATRY OFFICE AND PAYMENT POLICIES

We at Central Missouri Podiatry are committed to providing you with the best possible foot care. If you have medical insurance we are eager to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our office payment policy. Below you will find our office policy regarding payment contracts, insurance filing, co-pays, and collections.

Our office now requests a 24-hour cancellation notice otherwise we reserve the right to charge for the time scheduled for you.

- We request all patients update their patient information yearly.
- A current and valid insurance card will need to be presented at the time of your appointment. If you do not have your current or valid insurance card available to us, charges for the day will be your responsibility.
- Please notify us of any changes with insurance, telephone number, address, or employment.
- All co-pays are due at the time of service.
- We accept payment in the form of cash, check, or credit card.
  Returned checks and balances over 30 days are subject to additional collection fees.
- We will file to your insurance for you as a courtesy. You must realize, however that:
  1. Insurance is a contract between YOU and you INSURANCE COMPANY.
  2. Not all services are covered benefits. Some insurance companies refuse to cover certain services. We are unable to control or change the negotiated contract that you have with your insurance company.
- MEDICARE PATIENTS: We would like you to understand that accepting ASSIGNMENT means YOU are responsible for the Yearly Deductible and for the 20% (co-insurance) of what Medicare allows. You are also responsible for services should you co-insurance not pay this amount.
- FILING OF INSURANCE CLAIMS IS A COURTESY that we extend to our patients. However, all charges are YOUR responsibility NOT your insurance company's. We will make our best efforts to collect from your insurance, but if we are NOT SUCCESSFUL, YOU will be responsible for the unpaid balance.
- Should you need to request a copy of your medical records, you will need to obtain a release form from our office or a written letter with your signature is required. NO original records will be released. All X-Rays are the property of Central Missouri Podiatry and can be released to the patient but are required to be returned to our office in 15 days. In addition, a $100.00 deposit is required when the X-Rays are picked up. The deposit will be returned to you when you return the X-Rays. Allow 3 business days for the paperwork to be ready for pick up or mailed.
- A $25.00 fee is charged for any FMLA/Disability forms.
- HMO Patients:
  If you have an insurance that requires a referral from you Primary Care Physician, that referral must be presented at the time of your visit or we will not be able to provide services. **If you do not have a referral form and choose to be seen you will be responsible for paying the full amount at the time of that appointment.**
- PATIENTS WITHOUT INSURANCE:
  You are responsible for the FULL charge amount the day of the appointment. We will not bill you and no partial payments or payment arrangements will be made.
- ACCOUNT DELINQUENCY:
  All balances are the responsibility of the patient, and if your insurance has not paid their portion, this becomes your responsibility. Delinquent accounts sent to collections will have a collection fee attached. All collection accounts must be paid in full before future care at this office or medical records will be permitted.
- MEDICAID PATIENTS: Medicaid no longer pays for nail care and you are responsible for the Medicaid portion of the bill.