Regional Foot Centers
Dr. Thomas Bembynista, DPM

PATIENT INFORMATION & HISTORY

PATIENT NAME

First_____ *(preferred name)*_____ **Middle Initial** _____

Last_____ D/O/B _____ Age _____ Male/Female

*Marital Status*_____ ***Home Phone#***_____ ***Cell Phone#***_____

HOME ADDRESS

Street Name & #_____ City_____ State____ ZIP_____

E-Mail

_____SS#_____

Employer _____ Occupation _____

Primary DR. *Name & Phone*_____

Pharmacy *Name, Address,*& *Phone*_____

PRIMARY REASONS FOR VISIT

Heel pain fungal nails hammer toes ingrown toenail infected toenail bunion surgery consult foot pain

Wart Callous trim nails/callous new orthotics foot rash injury toe/foot/ankle neuropathy diabetic check

OTHER_____

PAYMENT TYPE

Insurance Card *(provide cards/ and driver license)*. Talk with insurance provider to understand coverage.

OR, cash payment. Dr Bembynista will disscuss charges.

ASSIGNMENT AND RELEASE

I hereby authorize Regional Foot Centers to furnish information to insurance carriers concerning my illness and treatments and to my referring physicians if so requested. I hereby assign to the physician all payments for medical services rendered to myself or to my dependence. I understand that I am responsible for any amount not covered by insurance. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____ Date _____
(Parent/or Guardian if Minor)

Regional Foot Centers
Dr. Thomas Bembynista, DPM

MEDICATION LIST

ALLERGIES

_____ _____

_____ _____

_____ _____

_____ _____

_____ *** Height_____ Weight_____ Shoe Size_____**

_____ ***Have you Had heart grafts, or joint replacements? Yes / No**

HEALTH HISTORY (Y [yes])

Insulin diabetic : _____(A1C_____) Rhuematoid Arthritis____ Osteoarthritis____ Hypertension_____ Anemia_____
Location/on chemo/remission

Cardiac disease_____ Liver disease _____ Gout _____ Neuropathy _____ Cancer_____

Phlebitis _____ Fainting history _____ Covid history_____ OTHER_____

SURGERIES/HOSPITALIZATIONS

_____

_____

_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Dr. Bembynista to use or disclose my personal health information as described below. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider. The released PHI may no longer be protected by federal privacy regulation. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice. It is available upon request.

PATIENT AUTHORIZES COMMUNICATION WITH FAMILY/FRIENDS REGARDING YOUR CARE AND TEST RESULTS.

NAME _____PH_____REL._____

NAME _____PH_____REL._____

PATIENT AUTHORIZES COMMUNICATION WITH FAMILY/FRIENDS REGARDING YOUR ACCOUNTING & BILLING

NAME _____PH_____REL_____

PATIENT AUTHORIZES COMMUNICATION WITH PRIMARY CARE PHYSICIAN OR OTHER PHYSICIAN

NAME _____

NAME _____

Information and reminders will be left on phone numbers provided by patient.

***Signature** _____(Patient/Guardian) **Date**_____

Dr. Thomas Bembynista

Diplomate, American Board Podiatric Surgery

Fellow, American College of Foot & Ankle Surgeons

NOTICE OF PRIVACY PRACTICES:

I acknowledge that I was provided with a copy of the Notice of Privacy Practices, and that I have read (or had the opportunity to read it if I so chose). I also acknowledge my understanding of the notice.

CONSENT OF TREATMENT:

I consent to such diagnostic procedures and medical care as deemed necessary, by the Doctor, for my treatment. I also consent to the taking of photographs, which will be used for medical education purposes.

FINANCIAL RESPONSIBILITY:

I understand when discussing any treatment recommended by Dr. Thomas Bembynista, I am responsible for all charges. I acknowledge that my insurance may not cover certain charges for reasons including but not limited to the following:

1) Not bringing or not getting a referral
2) Pre-certification is not obtained
3) Services are not covered
4) Insurance is not in effect

Initial_____

I understand that there is a $40 charge for any returned check. Account balances are due within 30 days unless payment arrangements are set up with our office. Outstanding account balances are turned over to a collection agency at 60 days. A 40% fee will be added to the outstanding balance to cover collection costs. Initial_____

Our office will file with your insurance company within business 5 days of your visit. I acknowledge that I am solely responsible for any charges my insurance company does not cover. I understand my insurance company may have co-pays, deductibles, and co-insurances. Initial_____

New patients are required to pay for services on the first visit. This includes co-pays, deductibles, and co-insurances. These fees will be reviewed with you and are generally $200 or less. It is important that you understand what your insurance policy covers. The deductible applies to the office visits even when a co-pay is noted on the insurance card. (Examples would be x-rays, injections, and office surgeries) Initial_____

I have read, understand, and agree to all of the above

Name of Patient (Please Print)_____

Signature of Financially Responsible Party _____Date_____

Name of Financially Responsible Party (Please Print)_____Date_____

Overland Park

8695 College Blvd. #220

Overland Park, KS 66210

Tel:913-894-0660

Green Hills

8530 N. Green Hills Rd.

Kansas City, MO 64154

Tel:816-455-3636

Fax:816-461-0393