



First Name: _____ **(Preferred Name):** _____
Middle Initial: _____ **Last Name:** _____

Date of Birth: ___ / ___ / ___ **Age:** _____ **Sex:** Male Female
Marital Status: _____ **Cell Phone #:** _____

Home Address:
Street _____ Apt #: _____
City _____ State _____ ZIP _____

Email _____

Primary Reason for Visit

Heel pain -fungal nails - hammer toes - ingrown toenail- bunion- foot pain 3D Custom orthotics - Other problem _____

Acknowledgement of privacy practices

I acknowledge I was provided with a copy of the notice of privacy practices and that I have read or I had the opportunity to read it. I also acknowledge my understanding of the notice

Consent for treatment

I consent to such diagnostic procedures and medical care is deemed necessary by the doctor for my problem that I verbally agreed to

I understand that Dr. Thomas F. Bembynista is an out-of-new-provider physician. If I am a Medicare patient, I was fully informed no services covered out of network.

For services that are performed a receipt with the proper CPT procedure code and I CD10 codes which are diagnostic codes will be forwarded upon request

For all out of network surgery performed at a participating surgical center we will file the claim directly with your carrier. Under the no surprise act your insurance must treat me as the same as in network. Normal deductibles and co-pays apply

I understand that payment for services are required at time of service

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

