KAWARTHA FOOT ORTHOTIC CLINIC

PATIENT INFORMATION FORM

Welcome to our clinic! At Kawartha Foot & Orthotic Clinic, we are dedicated to providing exceptional foot care solutions for individuals of all ages. Please help us get to know you better by providing the following information.

First Name: ________________________________ **Last Name**: __________________________________

Address: _____________________________ **City:** ___________________ **Postal Code:** _____________

Date of Birth (DD/MM/YY): ______________________________

Phone Number: *Home*______________________ *Cell*___________________ *Other* _________________

Email Address: ____

Preferred Method of Appointment Reminder (Circle One): ***Phone*** or ***Email*** or ***Text***

Occupation: ________________________________ **Employer:** __________________________________

Do you have extended health insurance (benefits)? Yes / No

If "Yes", which company? __________________ **Please see Page 4 for more details**

Emergency Contact: ______________________________ **Relationship:** _________________________

Phone Number: __________________________________

Family Physician: ______________________________ **Phone Number:** _________________________

Fax Number: _____________________________

Pharmacy: _____________________________________ **Location:** ____________________________

How did you hear about our clinic? (Please check one or explain)

- ○ Physician / Practitioner Referral
- ○ TV Advertisement
- ○ Google
- ○ RateMDs
- ○ Yellow Pages
- ○ Flyer
- ○ Newspaper
- ○ Family/Friend
- ○ Facebook
- ○ Location/Walk-By/Signage
- ○ Clinic Website
- ○ Radio Advertisement
- ○ Instagram
- ○ Yelp
- ○ Informational Session
- ○ Newsletters

Other *(Please Explain):*

____

____

Family, Friend or Colleague *(Provide Name)***:**

____

REASON FOR VISIT

Describe the foot problem you are experiencing:

____

____

Please mark area of concern:

MEDICAL HISTORY

Please check all that apply?

- ☐ Diabetes (Type: ☐ 1 or ☐ 2)
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Psoriatic Arthritis
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Hypertension (↑BP)
- ☐ High cholesterol
- ☐ Hypotension (↓BP)
- ☐ Stroke ________________
- ☐ Heart Attack _____________
- ☐ Angina

- ☐ Asthma
- ☐ Thyroid Disease
- ☐ Lung Disease
- ☐ Acid Reflux
- ☐ Bleeding Disorder
- ☐ Nerve Disorder
- ☐ Pregnant / Breastfeeding
- ☐ Bone / Osteoporosis

- ☐ Skin Condition: ____________________________
- ☐ Circulatory Disorder: ____________________________
- ☐ HIV / AIDs
- ☐ Tuberculosis
- ☐ Hepatitis

Other medical conditions not listed above:

____

Allergies (Drugs, Food, Environment, etc.):

____

Major surgery, fractures and/or implants:

____

Smoking History (IF yes - how long, how much and how often) ____________________________________

Alcohol History (IF yes - how long, how much and how often) ____________________________________

Height: ________ **Weight:** ________ **Commonly Used Shoes:** ____________________________ **Size:** ______

Current Medications

Please list current medications you are taking and reason for use if known:

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

ARE YOU ON BLOOD THINNING MEDICATION? YES / NO

If you would like us to contact your pharmacy to provide a medications list, please sign ______________________

FEE SCHEDULE AND CONSENT

Foot care services in Ontario are **NOT** covered by OHIP. However, most **Third Party Insurance & Extended Health Care Plans** do cover services provided by a foot specialist / chiropodist. Your visits may also be eligible for income tax health deduction purposes.

Fee Schedule:
Kawartha Foot & Orthotic Clinic's fee schedule is based on the Ontario Society of Chiropodists and the Canadian Federation of Podiatric Medicine's recommendations.
Prices may change on an annual basis. Notifications will be made if there is a change in the fee schedule.

Appointment Cancellations:

Your appointment time is reserved for you. A late cancellation or missed visit leaves a hole in the practitioner's day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than the required notice, or miss their appointment will be subject to the following cancellation fees:

Cancellation Fee: $30.00
Surgery Cancellation: $60.00

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN (If Applicable). I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE KAWARTHA FOOT & ORTHOTIC CLINIC OR MY INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS. I CONSENT FOR TREATMENT AND ANY ADDITIONAL TREATMENT TO BE PERFORMED BY KAWARTHA FOOT & ORTHOTIC CLINIC. AS A GUARDIAN YOU ARE DECLARING TO BE THE GUARDIAN OF THE PATIENT. ALL PERSONAL AND HEALTH INFORMATION IS KEPT CONFIDENTIAL.

Signature Patient or Guardian: ______________________ Date: ______________________

KAWARTHA FOOT ORTHOTIC CLINIC

Benefit Assignment Form

Only applicable if patient requires provider to submit electronically on the patient's behalf

Provider: Kawartha Foot and Orthotic Clinic
Address: 1600 Lansdowne St. W
City/Province: Peterborough
Postal Code: K9J 7C7
Phone Number: 705-743-3668

Patient: ___________________________________

Claim/ID Number: __________________________

Policy/Plan Number: ________________________

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided. I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment. I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.
If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

Message to the Plan member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.
I authorize the insurer and / or plan administrator and their service provider(s) to:
use my personal information for the above purposes.

exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.

exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.

exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.
I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

Additional Consent Applicable to Plane Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.
In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.
If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

____
Date:

____
Signature:

Print Name: ____________________________