Greater Washington
Advanced Podiatry
THE RIGHT FOOT DOCTOR

New Patient Form

Chris Majewski, DPM
FACFAS, FABMSP-S, FABMSP-P, FAPWC, FACLES, FAAWC, FACSM, CEC, CPDC, PMBA

Tanno Kaur, DPM

PATIENT DEMOGRAPHICS

First Name: _____ Last Name: _____
Social Security: ___ - ___ - ___ Gender: **F / M** Date of Birth: ___ / ___ / ___
Email: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Care Physician Information

Physician Name: _____ Physician Phone: _____
Other Treating Physician(s): 1 _____ 2 _____
Pharmacy of Choice & Phone Number: _____

How did you hear about our practice? (Please select all that apply.)

☐ Doctor Referral (Name: _____) ☐ Newspaper ☐ Internet (Source: _____)
☐ Friend/Family Member/Patient (Name: _____) ☐ Other (_____)

Other Information

Race/Ethnicity (Please Select One or More)

☐ Asian ☐ Hispanic or Latino ☐ American Indian or Alaska Native ☐ Black or African American
☐ White ☐ Unknown / Other

Primary Language (Select One)

☐ English ☐ Spanish ☐ Other

Employment Status (Select One)

☐ FT ☐ PT ☐ Not Employed ☐ Retired

Employer Name: _____

Financially Responsible Person: _____

If different than patient, please provide the following information for the Financially Responsible Person:

First Name: _____ Last Name: _____
Social Security: ___ - ___ - ___ Gender: **F / M** Date of Birth: ___ / ___ / ___
Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact Information:

Contact Name: _____ Relationship to Patient: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Greater Washington
Advanced Podiatry
THE RIGHT FOOT DOCTOR

New Patient Form

Chris Majewski, DPM
FACFAS, FABMSP-S, FABMSP-P, FAPWC, FACLES, FAAWC, FACSM, CEC, CPDC, PMBA

Tanno Kaur, DPM

MEDICAL HISTORY AND PHYSICAL FORM

First Name: _____ Last Name: _____

Reason for your visit today: _____

How long has this been a problem? _____

When does it occur? (Select all that apply) ☐ Morning ☐ Afternoon ☐ Evening ☐ Off and On ☐ All Day

Have you been to a Podiatrist before? ☐ Yes ☐ No If yes, please provide physician name: _____

Please list previous treatments (either prescribed or home remedies): _____

Please list three activities or hobbies: _____

Do you have a history of allergies / skin reaction / sickness to any of the following? ☐ Yes ☐ No

If yes, list reaction below:

Adhesive tape: _____
Anesthesia: _____
Aspirin: _____
Caffeine: _____
Codeine: _____
Cortisone: _____
Demerol: _____
Foods: _____
Iodine: _____
Latex: _____
Local Anesthetics: _____
Penicillin: _____
Sulfa: _____
Other, please list: _____

Please list or provide a list of your current medications and their dosages:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Does patient (Me) or a family member (F) have/had any of the following? (Please circle all that apply.)

Alcohol / Drug Addiction or Dependency	☐ Me	☐ F	GERD (Reflux) / GI ulcers **(circle one)**	☐ Me	☐ F	Phlebitis (blood clots in legs)	☐ Me	☐ F
Alzheimer's / Dementia	☐ Me	☐ F	Headaches / Migraines Headaches	☐ Me	☐ F	Poor Circulation / PVD	☐ Me	☐ F
Anemia – type	☐ Me	☐ F	Hearing Problems	☐ Me	☐ F	Rheumatic Fever / Scarlet Fever	☐ Me	☐ F
Arrhythmias – type	☐ Me	☐ F	Heart Disease	☐ Me	☐ F	Schizophrenia	☐ Me	☐ F
Arthritis - type	☐ Me	☐ F	Hepatitis A B C / Liver Disease	☐ Me	☐ F	Seizures / Epilepsy	☐ Me	☐ F
Arthritis - type	☐ Me	☐ F	High Blood Pressure	☐ Me	☐ F	STD's (Sexually Transmitted Diseases)	☐ Me	☐ F
Asthma Adult / Childhood **(circle one)**	☐ Me	☐ F	High Cholesterol	☐ Me	☐ F	Sickle Cell Trait / Disease	☐ Me	☐ F
Bleeding/Clotting Problems	☐ Me	☐ F	High Cholesterol	☐ Me	☐ F	Stroke / TIA's	☐ Me	☐ F
Cancer - type	☐ Me	☐ F	HIV / AIDS / ARC	☐ Me	☐ F	Thyroid problems (Hyper__ Hypo__)	☐ Me	☐ F
Depression / Anxiety Disorder/Bipolar	☐ Me	☐ F	Kidney/Renal Disease	☐ Me	☐ F	Tuberculosis	☐ Me	☐ F
Diabetes	☐ Me	☐ F	Lung Disease / Pulmonary Embolus	☐ Me	☐ F	Other, Please Specify:	☐ Me	☐ F
Emphysema / COPD	☐ Me	☐ F	Lyme's Disease	☐ Me	☐ F	Other, Please Specify:	☐ Me	☐ F
Glaucoma	☐ Me	☐ F	Nervous Condition - type	☐ Me	☐ F			
Gout	☐ Me	☐ F	Osteoporosis / Osteopenia **(circle one)**	☐ Me	☐ F	None of the above	☐ Me	☐ F

Chris Majewski, DPM
FACFAS, FABMSP-S, FABMSP-P, FAPWC, FACLES, FAAWC, FACSM, CEC, CPDC, PMBA

Tanno Kaur, DPM

MEDICAL HISTORY AND PHYSICAL FORM

Have you been hospitalized? ☐ Yes ☐ No

If so, please list reason and year: _____

Have you ever had surgery? ☐ Yes ☐ No

If so, please list type and year: _____

Smoking

Do you or have you ever smoked? ☐ Yes ☐ No

If yes, how many years? _____

How many cigarettes per day? _____

If you quit, how many years? _____

Alcohol Use

Do you or did you ever drink alcoholic beverages? ☐ Yes ☐ No

How many drinks will you consume in a day? _____

How many drinks will you consume in a week? _____

Recreational Drug Use

Do you or have you ever used illicit/recreational drugs? ☐ Yes ☐ No

If yes, which ones? _____

If you quit, how many years? _____

Reproductive Health (Women)

Are you currently pregnant? ☐ Yes ☐ No ☐ N/A

If yes, what is your due date? _____

Are you currently or have in the past used a contraceptive medication? _____

Greater Washington
Advanced Podiatry
THE RIGHT FOOT DOCTOR

New Patient Form

Chris Majewski, DPM
FACFAS, FABMSP-S, FABMSP-P, FAPWC, FACLES, FAAWC, FACSM, CEC, CPDC, PMBA

Tanno Kaur, DPM

Patient's Authorization and Assignment of Benefits

I hereby authorize the processing of my medical insurance either by electronic or manual method by GWAP, LLC. My signature authorizes payment for all major medical and/or durable medical equipment supplies and/or surgical benefits to which I am entitled from the listed insurer(s) above and/or by providing my insurance cards to the office to pay for services rendered to. I certify that the information, I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I recognize my financial obligation of any balance, copay, co-insurance, deductible, and non-covered services that may be required. This consent will end when my current treatment is completed or one year from the date signed below (whichever is the longer period).

Signature of Responsible Party **Date**

Print Name of Responsible Party **Relationship (if not patient)**

Medicare/Medicaid/Medigap Authorization

I request that payment of authorized Medicare or Medicaid benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to GWAP, LLC for any services furnished to me by a GWAP, LLC provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Responsible Party **Date**

Print Name of Responsible Party **Relationship (if not patient)**

Consent for Treatment

I certify that the information above is true and correct to the best of my knowledge. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance. I understand nail care provided to me at GWAP involves use of local anesthesia and debridement of the nail matrix, which insurance processes as a surgical procedure and may not be a covered procedure. I give permission to Dr. Majewski to administer and perform such procedures as they may be deemed necessary in the diagnosis and/or treatment of my feet and ankles.

Signature of Responsible Party **Date**

Print Name of Responsible Party **Relationship (if not patient)**

Chris Majewski, DPM
FACFAS, FABMSP-S, FABMSP-P, FAPWC, FACLES, FAAWC, FACSM, CEC, CPDC, PMBA

Tanno Kaur, DPM

HIPAA SUMMARY NOTICE OF PRIVACY PRACTICES

The 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.

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 you have identified as 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

- 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 contact 301.515.3338

I acknowledge that I was provided a copy of the Summary Notice of Privacy Practices and that I have read or had the opportunity to read if I so chose and understand the Notice. I have also been offered a copy of the Full Notice of Privacy Practices for my review. In addition, I authorize Greater Washington Advanced Podiatry, LLC access to my personal health information upon request.

Patient or Guardian Signature

Relationship (if not patient)

Print Name of Patient or Guardian

Date

Chris Majewski, DPM
FACFAS, FABMSP-S, FABMSP-P, FAPWC, FACLES, FAAWC, FACSM, CEC, CPDC, PMBA

Tanno Kaur, DPM

FINANCIAL POLICY

Welcome to Greater Washington Advanced Podiatry, LLC and thank you for selecting our practice. We are committed to providing you with the best possible care. If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our policy.

Your insurance is a contract between you, your employer, and the insurance company. It is your responsibility to understand the benefits of your plan. We cannot guarantee payment of your claims because your insurance company will not give us such guarantee. If your insurance company pays only a portion of your claim or rejects your claim, you and/or the policyholder should make any contact or inquiry with your insurer(s). Payment delays or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. Balances older than 30 days are subject to a $5.00 per month fee. Returned checks are subject to a $35.00 fee.

We participate in a number of health insurance plans. All patients are required to pay their co-pay/co-insurance at time of check in. Patients who do not pay their co-pay/co-insurance at time of visit will be charged an additional $50.00. In addition, HMO/ Managed Care patients must present a valid referral/authorization from their primary physicians at check in. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered" or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges for any service rendered. Patients are encouraged to contact their insurance company for clarification of benefits prior to services being rendered.

Medicare Patients: Please understand that we participate with Medicare. However, you are responsible for your 20% co-insurance, deductible, and/or any non-covered services. If Medicare has provided its reimbursement for services rendered and if your supplemental insurance does not respond within 30 days, then you become responsible for the balance.

Filings of insurance claims are a courtesy that we extend to our patients, however all charges are your responsibility. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We accept cash, check and all major credit cards for payment.

Missed appointments will be billed a $50.00 charge when canceled without a 24-hour notice.

For a copy of any medical record, there is a $25.00 Fee Plus $1.00 per page. This fee will also be charged for the completion of any form or letter that is required for your care.

If you believe your insurance carrier has erred or not adequately addressed your claims, you may file a grievance or appeal with the Maryland Insurance Administration, 410-468-2244 and/or The Health Advocacy Unit of the Maryland Attorney General, 410-528-1840

I have read and I understand the above financial policies. I personally guarantee to cover any charges that my insurance company does not cover or that I am responsible to pay regarding the medical care rendered to me. These policies are subject to change without prior written confirmation.

Patient or Guardian Signature

Relationship (if not patient)

Print Name of Patient or Guardian

Date

Chris Majewski, DPM
FACFAS, FABMSP-S, FABMSP-P, FAPWC, FACLES, FAAWC, FACSM, CEC, CPDC, PMBA

Tanno Kaur, DPM

LASER TREATMENT

Laser treatment can treat most toenail fungus by penetrating the nail and destroying the fungus (onchomycosis) embedded in and under the nail plate. The laser has no effect on skin or soft tissue. In clinical studies, there have been minimal adverse injuries, disabilities or known side effects, including but not limited to tingling, temporary numbness, redness, localized itching. As with any procedure, there is some risk of side effects that are unknown.

Please check each section below indicating your agreement:

- ☐ I understand that a result is not guaranteed
- ☐ I understand that the laser treatment for onychomycosis (fungus) is considered a cosmetic treatment and is not covered by insurance. No attempt to obtain authorization for payment from your insurance carrier will be made.
- ☐ I understand that clinical results may vary in different patients. I understand the fungus may not be completely destroyed, that the nail may become re-infected, or there may be other types of infection present. The nail may continue to be discoloured or not attach to the nail bed. This treatment will not change the shape, width, or other deformity of the nail plate.
- ☐ I understand it may be necessary to perform multiple treatments to obtain optimal results.
- ☐ I understand that photographs may be taken before and after my procedure, I further agree that these photographs can be used in any manner necessary for medical documentation or publication in compliance with HIPAA regulations.
- ☐ I understand the risks and alternatives involved in this procedure.
- ☐ I certify that I have read or have had read to me the contents of this form. I have had the opportunity to ask any questions that I had, and all my questions have been answered.

With all the above information taken into consideration, I am choosing to have wavelength non-invasive laser treatment for toenail fungus and will need to pay out of pocket.

The Board of Podiatric Medical Examiners wishes to inform you that under law of Maryland, you may not be charged a fee for podiatric goods or services which have been advertised as free. Nor may you be charged more than the reduced or discounted fee advertised for particular goods or services. If a reduced charge is applicable, then you will need to pay out of pocket for this procedure.

In addition, before a podiatrist may charge you a fee to treat immediately or within 72 hours from when a problem is diagnosed at the time you received the free, reduced, or discounted podiatric goods or services, you shall consent in writing to accept that treatment. The podiatrist shall explain to you whether he or she thinks that you need the treatment immediately or within 72 hours, or whether your condition does not require immediate treatment. The decision to accept treatment immediately or at a later date is always your decision.

If you desire to accept treatment immediately or within 72 hours of today, please sign this document as required by law. Please be aware that you may be financially responsible for payment of the goods, services, and/or office visit you receive.

Chris Majewski, DPM
FACFAS, FABMSP-S, FABMSP-P, FAPWC, FACLES, FAAWC, FACSM, CEC, CPDC, PMBA

Tanno Kaur, DPM

LASER TREATMENT (CONT.)

Information Provided:

- ☐ This podiatrist has explained to me the diagnosis of my condition and I understand it.
- ☐ This podiatrist has explained the treatment alternatives and their risks to me and I understand them.
- ☐ This podiatrist has explained the likely cost of each of the treatment alternatives and I understand it.
- ☐ This podiatrist has explained to me why I need the treatment immediately (within 72 hours of today) and I understand why.

Consent to Treatment

I have received free, reduced, or discounted goods, services or office visit care. I am accepting treatment today or within 72 hours of today's date and I fully understand that I may be charged for the treatment or office visit rendered. I agree to the terms of this agreement.

Patient Name

Patient Signature

Witness Signature

Podiatrist Signature