PASCO-HERNANDO FOOT & ANKLE
LAWRENCE J KALES, DPM, PA

To be completed by office staff:
Height _____ Weight _____ Blood Pressure Reading _____/_____

PATIENT INFORMATION

Patient's Name: _____
First Middle Last
Address: _____
City: _____ State: FL Zip Code: _____
Home Phone #: _____ Work/Cell #: _____
Social Security #: _____-_____-_____ Birth date: _____/_____/_____ Age: _____ Sex: Male Female
Marital Status: Single Married Partnered Separated Divorced Widowed
Race: White Black/African American Asian American Indian Native Hawaiian Declined
Ethnicity: Non- Hispanic/Latino Hispanic/Latino Refused/Does not know
E-mail Address: _____

Who can we leave a message with or discuss medical condition including diagnosis, treatment, payment and healthcare with?
Name: _____ Relation Spouse Daughter Son Other: _____
Emergency Contact: _____ Phone #: ( ) _____
Name/Relation
Name of Primary Physician: _____ Phone #: ( ) _____ Last visit date:____/_____/____
Best Estimate is acceptable
Name of Physician Treating your Diabetes: _____ Last visit date:____/_____/____
If different than your Primary
What is your average blood sugar reading? _____

Have you received a flu shot? **Yes No** Date of shot:____/_____/____
Have you received a pneumonia shot? **Yes No** Date of Shot:____/_____/____

RESPONSIBLE PARTY INFORMATION (applies to children and those patients who have a guardian)

Relationship to Patient: _____
Name: _____
First Middle Last
Address: _____
City: _____ State: FL Zip Code: _____
Home Phone #: ( ) _____ Work/Cell #: ( ) _____
Social Security #: _____-_____-_____ Birth date: _____/_____/_____ Age: _____

Do you wish to be exempt from reporting* functions? Yes No * Insurance Diagnosis and Medical Reporting
Per HIPAA guidelines can we leave a message on your machine regarding upcoming appointments? Yes No
I authorize e-mail contact: Yes No I authorize contact via text message: Yes No (Msg/data rates may apply)

Advanced Directives

Do you have advanced directives? **Yes No**
If yes: Have you completed a Do Not Resuscitate Order (DNR) **Yes No**
Do you have a living will? **Yes No**
Do you have a Durable Power of Attorney? **Yes No**
Do you have a surrogate decision maker? **Yes No** If so, Surrogate Name: _____
Has Advanced Care directive been discussed but you have made no decision at this time? **Yes No**
Due to Cultural or Religious beliefs do you not wish to discuss Advanced Directives? **Yes No**

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Medical History *** ARE YOU BEING TREATED FOR OR HAVE BEEN TREATED FOR ANY OF THE FOLLOWING?**

☐	DISORDER OF THE LIVER	☐	HYPERTENSION
☐	HEART MURMUR	☐	DISORDER MUSCULOSKELETAL SYSTEM
☐	BLOOD CLOT	☐	HEART DISEASE
☐	NEUROPATHY	☐	MENTAL ILLNESS
☐	ACUTE ARTHRITIS	☐	CANCER
☐	ALCOHOL ABUSE	☐	TYPE I DIABETES
☐	SLEEP APNEA	☐	TYPE II DIABETES
☐	DISORDER THE OF STOMACH	☐	HIV/AIDS
☐	CHOLESTEROL	☐	DISORDER OF SKIN
☐	BLOOD COAGULATION DISORDER	☐	DIFFICULTY BREATHING
☐	GOUT	☐	ASTHMA
☐	CHRONIC DEPRESSION	☐	DISORDER OF KIDNEY
☐	DISORDER OF THYROID	☐	CHRONIC HEPATITIS
☐	HISTORY OF ALLERGIES	☐	CEREBROVASCULAR ACCIDENT
☐	ANXIETY DISORDER	☐	ISCHEMIC STROKE

Please list any Previous Hospitalizations/Surgeries/Serious Illness and when:

- _____
- _____
- _____
- _____
- _____
- _____

Are you now or previously received Chemotherapy or Radiation Therapy? ◯ Yes ◯ No

Are you currently Pregnant? ◯ Yes ◯ No If yes, How many weeks?

Are you currently nursing? ◯ Yes ◯ No

Social History

Have you had two or more falls within the last 12 months? ◯ **Yes** ◯ **No**

Use of Alcohol: ◯ Never ◯ No Longer Use ◯ History of Alcohol Abuse ◯ Currently Use ◯ Rare ◯ Occasional ◯ Moderate ◯ Daily

Use of Tobacco: ◯ Never ◯ Quit How Long Ago? _____ **Current Use:** ◯ Rare ◯ Occasional ◯ Moderate ◯ Daily

Do you have a history of substance abuse? ◯ Yes ◯ No If yes, what substance(s)? _____

Exercise: ◯ Never ◯ Rare ◯ Occasional ◯ Weekly ◯ Several times a week ◯ Daily

Allergies: *** PLEASE MARK ANY ALLERIGES YOU MAY HAVE, PLEASE LIST ANY NOT SHOWN**

☐ NO KNOWN ALLERGIES	☐ PREDNISONE	☐ FOODS:
☐ ADHESIVES/TAPE/BANDID	☐ PENICILLIN	
☐ ASPIRIN	☐ RADIOGRAPH DYE	
☐ CODEINE	☐ SEDATIVES	☐ OTHER:
☐ CORTISONE	☐ SILVER	
☐ IODINE	☐ SULFA	
☐ LATEX	☐ TETANUS	
☐ LOCAL ANESTHESIA	☐ SHELLFISH	
☐ NSAIDS	☐ SEASONAL ALLERGIES	

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Pharmacy Name: _____ **Phone # ( ) _____**

Address: _____

Medications: * PLEASE LIST NAME AND DOSAGE OF YOUR CURRENT MEDICATION
Do you take medication on a daily basis, including pills, injectable, or herbs? ◯ Yes ◯ No ◯ See attached list

Medication Name:	**Dosage:**
Medication Name:	**Dosage:**
Medication Name:	**Dosage:**
Medication Name:	**Dosage:**
Medication Name:	**Dosage:**
Medication Name:	**Dosage:**
Medication Name:	**Dosage:**
Medication Name:	**Dosage:**
Medication Name:	**Dosage:**
Medication Name:	**Dosage:**

I authorize Dr. Kales to download my medication history and Rx benefits into my account from an Rx clearinghouse.

_____ _____
Patient Signature **Date**

REVIEW OF SYSTEMS: * PLEASE CHECK THE BOX IF YOU ARE CURRENTLY EXPERIENCING, OR HAVE HAD THE FOLLOWING:

- **Cardiovascular**

☐ ANGINA/CHEST PAIN ATRIAL
☐ FIBULATION
☐ CALF PAIN WHEN EXERCISING
☐ CLAUDICATION
☐ COLD HANDS/FEET
☐ CONGESTIVE HEART FAILURE
☐ EDEMA/SWELLING FAINTING
☐ HEART ATTACK
☐ LEG PAIN WHEN WALKING
☐ MITRAL VALVE PROLAPSE
☐ PALPATIONS
☐ PHELIBITIS
☐ PVD
☐ SHORT OF BREATH SYNCOPE
☐ VALVE PROBLEMS
☐ VARICOSE VEINS
☐ VASCULAR DISEASE

- Hematological

☐ Lymphatic AIDS/HIV
☐ ANEMIA
☐ BLEEDING/BRUISING
☐ BLOOD THINNERS
☐ CLOTTING DISORDER
☐ HEMOPHELIA INCREASED
☐ BLEEDING
☐ PAST TRANSFUSION
☐ SICKLE CELL
☐ SLOW TO HEAL

- **Integumentary**

☐ ATHLETE'S FOOT BLISTERS
☐ CHANGE IN HAIR OR NAILS
☐ CONTACT DERMATITIS
☐ DISCOLORATION
☐ DRY SCALY SKIN ECZEMA
☐ GROWTH ON SKIN
☐ ITCHINESS
☐ KELOIDS
☐ LESIONS
☐ PSORIASIS
☐ RASH

- **Musculoskeletal**

☐ ARTHRITIS BACK PAIN
☐ BURSITIS
☐ JOINT INSTABILITY JOINT
☐ PAIN /SWELLING/STIFFNESS
☐ MUSCLE PAIN
☐ NECK PAIN
☐ PRIOR FRACTURE/SPRAIN
☐ RESTLES LEGS
☐ SCIATICA
☐ TENDONITITS
☐ WEAKNESS OF LIMBS

- **Neurological**

☐ DIZZINESS
☐ FAINTING
☐ FOCAL WEAKNESS
☐ HEAD INJURY
☐ LIGHT HEADED
☐ NERVOUS DISORDER
☐ NEUROPATHY
☐ NUMBNESS
☐ PARALYSIS
☐ PARESTHESIA
☐ POOR BALANCE
☐ RECENT SEIZURE
☐ TINGLING
☐ TREMORS

_____ If you are not experiencing any of the symptoms please initial acknowledging you that none of the above apply currently or previously

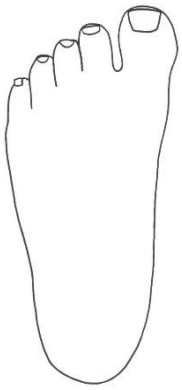
If completing this electronically you may skip the picture portion

PASCO-HERNANDO FOOT & ANKLE
LAWRENCE J KALES, DPM, PA

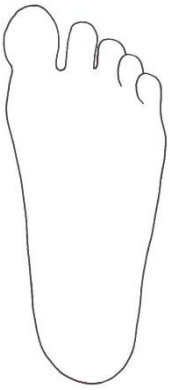
What specific problem(s) bring you to our office today? _____ What is your shoe size: _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

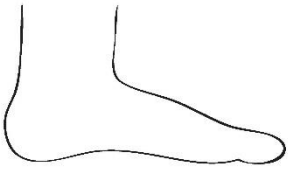
LEFT FOOT



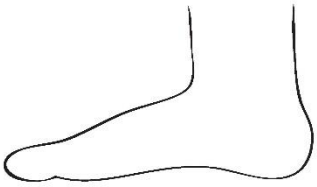
TOP OF FOOT



BOTTOM OF FOOT

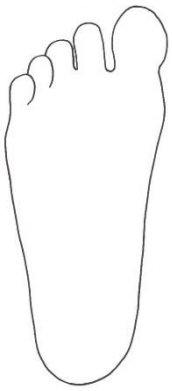


INNER LEFT

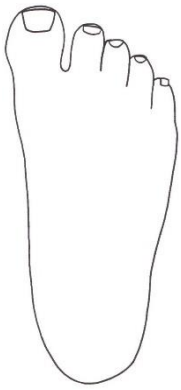


OUTER LEFT

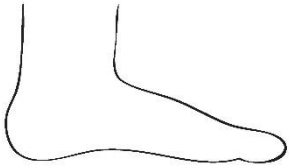
RIGHT FOOT



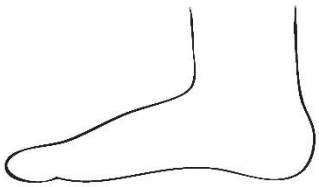
BOTTOM OF FOOT



TOP OF FOOT



INNER RIGHT



OUTER RIGHT

How long ago did this problem first start? ◯ Days ◯ Weeks ◯ Months ◯ Years ◯ N/A

Has this condition caused pain (symptoms) in the past or present? ◯ Yes ◯ No

Is your pain disabling? ◯ Yes ◯ No Did your pain or problem: ◯ Start all of a sudden ◯ Gradually develop over time

How would you describe your pain? ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing ☐ Other _____

How would you rate your pain on a scale of 1 to 10 (Please Circle)
(Minimal Pain) ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 (Worst Pain Possible)

Location: Please indicate where you are experiencing pain
Right: ☐ Foot ☐ Ankle ☐ Toe ☐ Heel
Left: ☐ Foot ☐ Ankle ☐ Toe ☐ Heel

Since the time your pain or problem has begun, has it: ◯ Gotten Better ◯ Worsened ◯ Stayed the same

Does the following make your pain or problem feel worse?
☐ Morning ☐ Night ☐ Applying weight walking/standing ☐ Daily Activities ☐ Resting ☐ Exercising ☐ Dress Shoes ☐ High Heels ☐ Flat Shoes ☐ Closed Shoe ☐ N/A ☐ Other: _____

Does anything make the problem or pain better? ◯ N/A ◯ Yes ◯ No What? _____

Is this pain/problem the result of an injury? ◯ N/A ◯ Yes ◯ No What happened? _____

If yes, was it work related? ◯ Yes ◯ No What happened? _____

Have you ever been treated by a foot specialist? ◯ Yes ◯ No When _____

Do you ever get cramps, tightening of the muscles or burning in legs? ◯ Yes ◯ No ◯ Sometimes
TOENAIL TREATMENT ONLY: Does your pain and discomfort increase as the nail grows and becomes thickened and/or ingrown? ◯ Yes ◯ No

PASCO-HERNANDO FOOT & ANKLE
LAWRENCE J KALES, DPM, PA

DO I NEED A TEST FOR P.A.D?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to different parts of your body, including legs and feet, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores, difficulty in controlling blood pressure or symptoms of stroke. People with PAD are at a more significantly increased risk for stroke and heart attack. Answers to the following questions will help to determine if you are at risk for PAD and a vascular exam will help us better assess your vascular health status.

NAME: _____ DATE: _____

CIRLCE "YES" OR "NO"

1. Do you have foot, calf, buttock, hip or thigh discomfort (aching fatigue tingling, cramping or pain) when you walk which is relieved by rest? **YES** **NO**
2. Do you experience any pain at rest in your lower legs or feet? **YES** **NO**
3. Do you experience foot or toe pain that often disturbs your sleep? **YES** **NO**
4. Are your toes or feet pale, discolored or blue? **YES** **NO**
5. Do you have skin wounds that are slow to heal? (8 – 12 weeks) **YES** **NO**
6. Has your doctor ever told you that you have diminished pedal pulses? **YES** **NO**
7. Have you suffered a severe injury to your legs or feet? **YES** **NO**
8. Do you have an infection of the legs or feet that may be gangrenous? (black skin tissue) **YES** **NO**

Patient signature: _____

CLARIFICATION OF AT RISK AND PRIMARY PODIATRIC FOOT CARE GUIDELINES FOR ALL INSURANCES

We are required to inform you that the AT RISK and Primary podiatric care guidelines for palliative care have been clarified by your insurance carriers. Services that are considered to be routine care include the cutting or removal of corns and calluses, the trimming, cutting, clipping of nails; other hygienic and preventive measures considered self-care (i.e. cleaning and soaking and the use of skin creams).

AT RISK PATIENTS:
A patient who has specific systemic disease (metabolic, such as diabetes mellitus- medication dependent, vascular or neurologic). This disease has resulted in the patient having severe circulatory embarrassment or areas of diminished sensation in their leg or foot. That patient requires the services of a physician (DPM, MD, DO) and has seen their physician at least once in the last 6 months. If these qualifications are met, the insurance carrier will pay for routine foot care. We will also contact your primary care doctor for you to obtain at risk podiatric care certification. Most insurance companies will cover routine foot care approximately every 90 days.

Medical conditions not associated with complication of wound healing such as blindness, upper body muscle weakness, arthritis of the hand or back, do not demonstrate at risk status.

PRIMARY PODIATRIC FOOT CARE:
Your insurance carrier considers the treatment of mycotic nails a covered service in only very specific, limited situations. The presence of a fungus infection of the nail does not automatically qualify. The fungus infection in the nail must be causing the nail to be abnormally thick or dystrophic, and that nail must in turn be causing either pain or a secondary infection or be causing marked limitation in ambulation for the patient.

Please be advised that all other podiatric related diagnosis will be considered as covered services. These include but are not limited to the treatment or toenail infections, skin disease including wart-like lesions, foot and leg ulcers, heel pain, painful bunions, painful hammertoes, gout, foot and ankle sprains, strains and fractures, and any traumatic injury. Treatment of circulatory and neuropathic disease is also covered if symptoms are present. Most insurance companies will cover routine foot care approximately every 90 days.

Our offices are aware that the need to continue to provide complete, comprehensive podiatric care to our patients. Therefore, it is imperative that all symptoms are noted on the history form so that we can assist you. It is required for covered primary foot care to have an updated medical history every year or sooner if necessary.

I hereby give Lawrence J Kales DPM permission to examine and treat my feet medically, surgically, or orthopedically and to photograph or televise any work he does providing it be used for educational purposes and/or to document my care. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. Any diagnostic procedures, including x-rays and photographs are the property of the office. Any fees charges are for interpretive purposed only and not the cost of the x-ray itself. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law.
To the best of my knowledge, I have answered the questions on these forms accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status or insurance changes.

_____ _____

Patient Signature Date

OFFICE AND FINANCIAL POLICIES FOR LAWRENCE J KALES, DPM PA

_____ I request that the payment of Authorized Medicare/Insurance Benefits be made either to me or on my behalf for any services furnished by Lawrence J Kales, DPM. I authorize any holder of medical information about me to release to CMS/Insurance Carriers and its agents any information needed to determine these benefits or benefit related to services. I understand and agree that I am responsible for all charges incurred whether or not paid by above insurance for the balance of any professional services rendered. I understand that I am responsible for any charges incurred should my account be sent to a collection agency and for any returned checks. I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services. I authorize and direct payments to Dr. Kales for the medical and/or surgical benefits payable under the terms of my insurance. I understand the above and agree to comply.

_____ All professional services rendered are charged to the patient. The necessary form will be completed to help expedite insurance carrier payments. However, THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF ANY INSURANCE COVERAGE. All payment for services rendered are due at the time of services unless prior arrangements have been made with the office.

_____ We are participating providers with your insurance company. We will accept assignment on all insurance patients for covered services and will accept the charge determination of the carrier for services rendered. The patient is responsible for all deductible and co-pay amounts set forth by the insurance company. Any services that your insurance company does not fully cover will be your responsibility.

_____ MEDICARE PATIENTS: Please be aware that your deductible is $183.00 for 2017. Please be sure that we have your secondary insurance information on file. If your plan does not cover your deductible, you will be responsible for that amount. Please note that if you do not have a secondary insurance plan, you will be responsible for 20% of the Medicare allowed billed amount.

_____ Please note that upon receiving your Explanation of benefits from your insurance carrier, you may notice that the CPT or procedure code billed is classified as "surgery" even though surgery may not have been performed. This is a CPT classification procedure for which we have no control. This procedure is coded by CMS and they determine its type of service. Please call the office if you have any further questions.

____ I have received a copy of Lawrence J. Kales, DPM, PA HIPAA Privacy Notice.

I have read the document and I fully understand the information in it. All my questions regarding the polices have been answered to my satisfaction as of this date.

_____ _____

Patient Signature **Date**

PASCO-HERNANDO FOOT & ANKLE

Lawrence J. Kales, DPM, PA
Diplomat American Board of Ambulatory Foot Surgery

Dear Valued Patients,

We thank you for choosing Pasco-Hernando Foot and Ankle for all of your foot and ankle needs. As we continue to fight the spread of COVID-19, we want to assure you that we are taking every measure to keep patients, doctors, and staff members as safe as possible. Aside from properly donning personal protective equipment such as face masks and gloves, frequent hand washing and performing pre-visit screenings to determine the need to reschedule appointments for patients who are feeling ill or if the patient has been in contact with someone who tested positive for COVID-19. We have also taken steps to practice social distancing whenever possible and allow additional time for thorough sanitation.

To accomplish limiting contact with others and to expedite visits, each patient on our schedule is appointed a specific block of time according to their individual care plan. As a courtesy we call each patient to remind them of their upcoming appointment, this provides the patient the opportunity to reschedule if needed. Patients that fail to arrive to their appointment without rescheduling cause a disruption in clinic flow and can prolong other patients from receiving the treatment they need.

Because it is our goal to provide the highest quality of care in a timely manner, **as of 01/01/2021 we will be enforcing a strict 24-hour cancelation policy.** If you need to cancel or reschedule your appointment and do not contact the office at least 24 hours prior to your appointment time **a $35 fee will be assessed. The fee is not processed through insurance and will be the patient's responsibility.** We will evaluate any extenuating circumstances on a case-by-case basis.

We hope that you understand our position and appreciate the efforts we continue to make in order to accommodate our patients needs.

Stay safe wherever you may go. Keep wearing your masks and smile with your eyes.

X _____

Patient Signature Date

Bayonet Point
7117 S.R. 52
Hudson, Florida 34667

Notice of Privacy Practices for Protected Health Information (HIPAA)

"This Notice Describes How Medical Information about You May Be Used and Disclosed And How You May Get Access To This Information". Please Review It Carefully!

We Safeguard Information about Your Health and Person:

We collect information from you and store it in a medical record as well as on a computer. Charts are stored in a secure area and available only to designated staff and only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for a service of computer operations.

Typical Uses and Disclosures of Medical Information:

We collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians and insurance and billing personnel. We may use your medical information for treatment and care, payment to insurers and for healthcare operations. Outside our office, we restrict disclosure to those people, entities and agencies for whom you authorize disclosure such as other healthcare providers (doctors, nurses, extended care facilities), insurance companies, billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- When required by law
- Public health activities (deaths, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors
- Organ tissue donation
- Research, provided authorization is IRB-approved or privacy-board approved
- Emergencies or to avert serious threat to health or safety
- Specialized government functions (military, inmates)
- Worker's compensation
- Disaster relief

We will not use or disclose your medical information for any purpose not listed without specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

Patient Privacy Rights:

You Have The Right To:

- Inspect and copy medical information from your chart. You may submit a written request to our office and pay the copy fee and received a copy of your record. We must respond within 30 days if the record is readily available and within 60 days if it is not readily available. You may also get an electronic copy if we have one available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed to our office. We must respond within 60 days.
- Received an accounting of any disclosures made from your record over the last six years, starting April 14, 2003. You can get this written request directed to our office. We must respond within 60 days.
- Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not supercede the typical disclosures noted above. You may revoke or restrict the consent. We cannot disclose self-pay services if you object.
- Request confidential communications. All communications in our office are confidential with a written request directed to our office.
- Not have your protected health information sold for marketing purposes.
- Opt out of receiving fund-raising communications
- Receive a copy of this notice by printing it or with a written request directed to this office, and a copy of this notice will be given with all new patient packets

We may contact you for appointment reminders, and we may provide you with information about health-related or product benefits and services.

Each patient is given a copy of the Privacy Notice and an opportunity to review and understand it.

Our Responsibilities under HIPAA:

We are required by Law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice.

We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change, copies will be made available.

You can submit a complaint about our privacy policy or its execution either verbally or in writing to our PRIVACY OFFICER at our office:

Pasco Hernando Foot and Ankle
7117 State Road 52
Hudson, FL 34667

If you get no resolution to your complaint, you can send a written statement to this office of the Secretary of Health and Human Services.

Effective date of Notice: April 2011 **Amended Dates: August 2017**