

# Kaplansky

Foot and Ankle Centers

**Columbus Office**  
1275 Olentangy River Rd Ste 10  
Columbus, OH 43212  
P: (614) 291-5555  
F: (614) 291-7720

**Dr. David Kaplansky**  
**Dr. Anthony Cozzolino**  
columbusohiopodiatrist.com

**Reynoldsburg Office**  
7509 East Main Street  
Reynoldsburg, OH 43068  
P: (614) 868-5555  
F: (614) 868-5561

\* REQUIRED FIELDS IN **BOLD** \*

**DATE:** \_\_\_\_\_

## **IDENTIFICATION:**

**LEGAL FIRST NAME:** \_\_\_\_\_ **MI:** \_\_\_\_\_ **LEGAL LAST NAME:** \_\_\_\_\_

**FIRST NAME USED:** \_\_\_\_\_ **LEGAL SEX:** **MALE / FEMALE** (circle)

**SSN:** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_

## **CONTACT:**

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_

**MOBILE PHONE:** \_\_\_\_\_ **CONSENT TO TEXT:** **YES / NO** (circle)

**HOME PHONE:** \_\_\_\_\_ **WORK PHONE:** \_\_\_\_\_

**CONSENT TO AUTOMATED CALLS (appointments, results, etc):** **YES / NO** (circle)

**PATIENT EMAIL:** \_\_\_\_\_

**CONTACT PREFERENCE:** **MOBILE # / HOME # / WORK # / EMAIL / PATIENT PORTAL\*** (circle)

**\*\* PATIENT PORTAL ACCESS - appointments, medical records, billing and more \*\***  
**EASY IN-OFFICE REGISTRATION - ask our team to get you started while you're here.**

## **DEMOGRAPHICS:**

**LANGUAGE:** \_\_\_\_\_ **RACE:** \_\_\_\_\_ **ETHNICITY:** \_\_\_\_\_

**MARITAL STATUS:** \_\_\_\_\_ **GENDER IDENTITY:** \_\_\_\_\_ **PRONOUNS:** \_\_\_\_\_

## **ADDITIONAL INFORMATION:**

**PATIENT CARE SUMMARY & LETTER DELIVERY PREFERENCE:** **PATIENT PORTAL / PAPER** (circle)

**HOW DID YOU HEAR ABOUT US?** \_\_\_\_\_

## **EMPLOYMENT:**

**EMPLOYER NAME:** \_\_\_\_\_ **EMPLOYER PHONE:** \_\_\_\_\_

**USUAL OCCUPATION (CURRENT /MOST RECENT):** \_\_\_\_\_

**USUAL INDUSTRY (NOTE IF CURRENT STUDENT):** \_\_\_\_\_

New Patient Registration

**CARE TEAM:**

PRIMARY CARE PROVIDER: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

**EMERGENCY CONTACT:**

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

**NEXT OF KIN:**

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

**GUARDIAN:**

FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_ LAST NAME: \_\_\_\_\_

**GUARANTOR (NAME TO WHOM STATEMENTS ARE SENT):**

RELATIONSHIP TO GUARANTOR (circle one) :

SELF / SPOUSE / CHILD / CHILD (MOTHER'S INS.) / CHILD (FATHER'S INS.) / OTHER (LIST BELOW)

\*OTHER: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_ LAST NAME: \_\_\_\_\_

ADDRESS SAME AS PATIENT: YES / NO (circle) \*IF NO, COMPLETE ADDRESS FIELDS BELOW

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

**INSURANCE INFORMATION:**

PRIMARY INSURANCE: \_\_\_\_\_ MEMBER ID: \_\_\_\_\_

POLICY HOLDER NAME: \_\_\_\_\_ POLICY HOLDER D.O.B.: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_ MEMBER ID: \_\_\_\_\_

POLICY HOLDER NAME: \_\_\_\_\_ POLICY HOLDER D.O.B.: \_\_\_\_\_

**PHARMACY INFORMATION:**

NAME / LOCATION: \_\_\_\_\_ PHONE: \_\_\_\_\_

**MEDICATION LIST:**PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING OR PROVIDE A COPY OF MEDICATION LIST

| MEDICATION | DOSAGE | MEDICATION | DOSAGE |
|------------|--------|------------|--------|
|            |        |            |        |
|            |        |            |        |
|            |        |            |        |
|            |        |            |        |
|            |        |            |        |

**VACCINATIONS:**

LAST FLU: \_\_\_\_\_ LAST PNEUMONIA: \_\_\_\_\_ LAST COVID-19: \_\_\_\_\_

## **ALLERGIES:**

☐ NONE    ☐ LATEX    ☐ ADHESIVE TAPE    ☐ IODINE    ☐ SULFA    ☐ PENICILLIN    ☐ INSECTS  
☐ OTHER: \_\_\_\_\_

## **FAMILY MEDICAL HISTORY:**

PLEASE INDICATE **WHICH** IMMEDIATE FAMILY MEMBER (MOTHER, FATHER, BROTHER AND / OR SISTER)

☐ DIABETES \_\_\_\_\_    ☐ CANCER \_\_\_\_\_  
☐ HEART DISEASE \_\_\_\_\_    ☐ NEUROLOGICAL PROBLEMS \_\_\_\_\_  
☐ BLEEDING DISORDERS \_\_\_\_\_    ☐ OTHER \_\_\_\_\_

## **SOCIAL HISTORY:**

USE OF TOBACCO/NICOTINE: ☐ NEVER    ☐ SMOKER: \_\_\_\_\_ PKS/DAY FOR \_\_\_\_\_ YEARS    ☐ QUIT: DATE: \_\_\_\_\_

USE OF ALCOHOL:    ☐ NEVER    ☐ YES, DRINKS / WEEK: \_\_\_\_\_    ☐ QUIT: DATE: \_\_\_\_\_

USE OF RECREATIONAL DRUGS: ☐ NEVER    ☐ YES, DRUG: \_\_\_\_\_    ☐ QUIT: DATE: \_\_\_\_\_

USE OF CAFFEINE:    ☐ NEVER    ☐ YES, CUPS / DAY: \_\_\_\_\_

## **MEDICAL HISTORY:**

PLEASE INDICATE ALL THAT APPLY

|   |   |
|---|---|
| <input type="checkbox"/> AIDS / HIV                               | <input type="checkbox"/> HEART DISEASE / MURMUR / ANGINA    |
| <input type="checkbox"/> ANEMIA OR BLEEDING DISORDER              | <input type="checkbox"/> HEPATITIS OR JAUNDICE              |
| <input type="checkbox"/> ARTHRITIS (RHEUMATOID OR OSTEOARTHRITIS) | <input type="checkbox"/> HIGH CHOLESTEROL / DYSLIPIDEMIA    |
| <input type="checkbox"/> ARTIFICIAL JOINTS                        | <input type="checkbox"/> HYPERTENSION (HIGH BLOOD PRESSURE) |
| <input type="checkbox"/> ASTHMA                                   | <input type="checkbox"/> HYPOTHYROIDISM                     |
| <input type="checkbox"/> BACK PROBLEMS / PAIN                     | <input type="checkbox"/> KIDNEY DISEASE / DIALYSIS          |
| <input type="checkbox"/> BLOOD CLOTS / DVT                        | <input type="checkbox"/> LIVER DISEASE                      |
| <input type="checkbox"/> CANCER                                   | <input type="checkbox"/> MRSA                               |
| <input type="checkbox"/> CHEMICAL DEPENDENCY                      | <input type="checkbox"/> ORGAN TRANSPLANT                   |
| <input type="checkbox"/> CHEST PAIN                               | <input type="checkbox"/> OSTEOPOROSIS                       |
| <input type="checkbox"/> CHRONIC PAIN SYNDROME                    | <input type="checkbox"/> PACEMAKER                          |
| <input type="checkbox"/> CIRCULATORY PROBLEMS / PVD               | <input type="checkbox"/> PHLEBITIS                          |
| <input type="checkbox"/> CORONARY ARTERY DISEASE                  | <input type="checkbox"/> RADIATION THERAPY                  |
| <input type="checkbox"/> DEPRESSION / ANXIETY                     | <input type="checkbox"/> RAYNAUD'S DISEASE                  |
| <input type="checkbox"/> DIABETES                                 | <input type="checkbox"/> RESPIRATORY / LUNG DISEASE         |
| <input type="checkbox"/> EDEMA                                    | <input type="checkbox"/> SPECIAL DIET                       |
| <input type="checkbox"/> EPILEPSY / SEIZURES                      | <input type="checkbox"/> STROKE                             |
| <input type="checkbox"/> FAINTING                                 | <input type="checkbox"/> SUBSTANCE ABUSE                    |
| <input type="checkbox"/> FIBROMYALGIA                             | <input type="checkbox"/> SWELLING OF ANKLES OR FEET         |
| <input type="checkbox"/> FOOT DEFORMITY                           | <input type="checkbox"/> TUBERCULOSIS                       |
| <input type="checkbox"/> FOOT AND / OR LEG CRAMPS                 | <input type="checkbox"/> ULCERS                             |
| <input type="checkbox"/> GOUT                                     | <input type="checkbox"/> VARICOSE VEINS                     |
|   | <input type="checkbox"/> OTHER _____                        |

## **SURGICAL HISTORY:**

PLEASE LIST ALL PRIOR SURGERIES

| TYPE OF SURGERY | DATE | TYPE OF SURGERY | DATE |
|-----------------|------|-----------------|------|
|                 |      |                 |      |
|                 |      |                 |      |
|                 |      |                 |      |
|                 |      |                 |      |
|                 |      |                 |      |

## **VITAL SIGNS:**

\*\* BLOOD PRESSURE, PULSE & TEMPERATURE MAY BE TAKEN BY MEDICAL ASSISTANT \*\*

WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ BLOOD PRESSURE: \_\_\_\_\_ / \_\_\_\_\_ PULSE: \_\_\_\_\_ TEMP.: \_\_\_\_\_

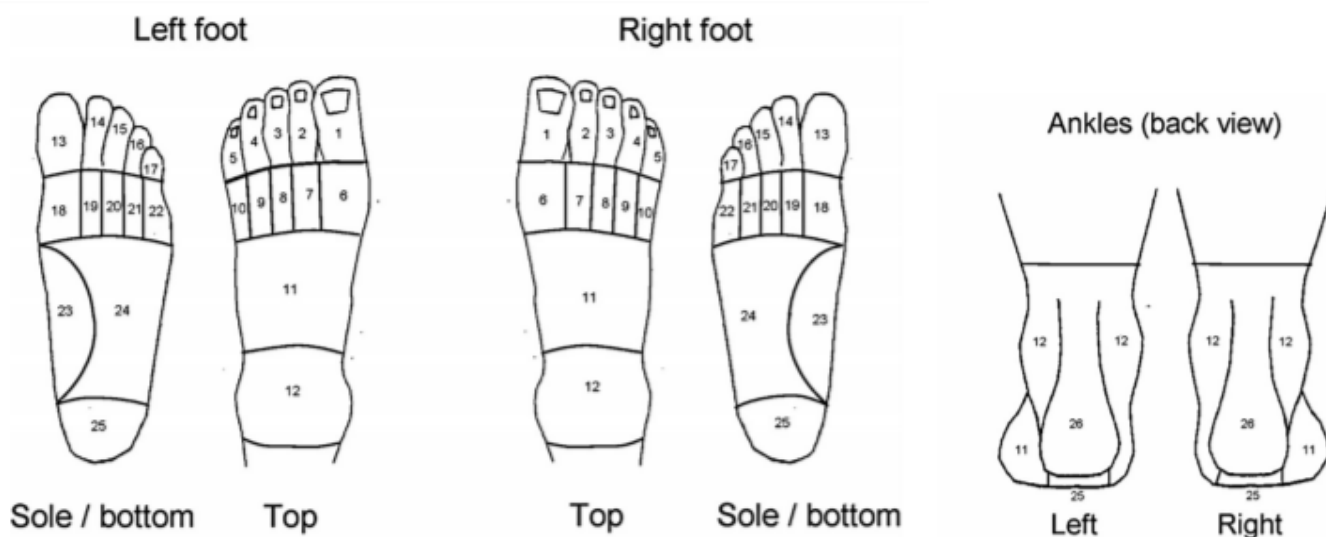
SHOE SIZE: \_\_\_\_\_ MISC. INFO: \_\_\_\_\_

NOTES: \_\_\_\_\_

## **CURRENT PROBLEM (CHIEF COMPLAINT):**

DESCRIBE THE FOOT OR ANKLE PROBLEM YOU ARE CURRENTLY EXPERIENCING: \_\_\_\_\_

WHERE IS THE PAIN / PROBLEM LOCATED? (PLEASE MARK PICTURES BELOW)



HOW LONG AGO DID THIS PROBLEM FIRST START? \_\_\_\_\_ ☐ DAYS ☐ WEEKS ☐ MONTHS ☐ YEARS

DID YOUR PAIN OR PROBLEM BEGIN: ☐ SUDDENLY ☐ GRADUALLY ☐ DEVELOPED OVER TIME

SINCE PROBLEM STARTED, HAS IT REMAINED? ☐ THE SAME ☐ BECOME WORSE ☐ IMPROVED

HOW WOULD YOU DESCRIBE YOUR PAIN?

☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ ITCHING ☐ BURNING ☐ RADIATING ☐ STABBING  
☐ THROBBING ☐ OTHER: \_\_\_\_\_

IS PAIN? ☐ MILD ☐ MODERATE ☐ STRONG ☐ SEVERE

PAIN IS (WORSE) WHILE:

☐ WALKING ☐ STANDING ☐ RUNNING ☐ RESTING ☐ HIGH HEELS ☐ WITH PRESSURE  
☐ FLAT SHOES ☐ CLOSED TOE SHOES ☐ GETTING UP IN THE AM ☐ NIGHT TIME ONLY  
☐ AFTER SITTING FOR LONG PERIODS OF TIME ☐ OTHER: \_\_\_\_\_

HOW ARE YOU CURRENTLY TREATING THIS PROBLEM? \_\_\_\_\_

PERCENTAGE OF THE DAY YOU SPEND ON YOUR FEET: ☐ 0% ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

HAS ANY OTHER DOCTOR, URGENT CARE, OR HOSPITAL TREATED YOUR PROBLEM? ☐ YES ☐ NO

IF YES, PROVIDE NAME OF DOCTOR / FACILITY: \_\_\_\_\_

HAVE YOU HAD IMAGING (X-RAYS / MRI) DONE PREVIOUSLY? ☐ YES ☐ NO

IF YES, WHERE & WHEN: \_\_\_\_\_

IS THIS PROBLEM A WORK / CAR RELATED INJURY? ☐ YES: DATE OF INJURY: \_\_\_\_\_ ☐ NO

IF YES, PLEASE EXPLAIN: \_\_\_\_\_

**\*\*\* DIABETIC PATIENTS ONLY \*\*\***

TYPE: ☐ I (ONE) ☐ II (TWO) CONTROLLED WITH: ☐ INSULIN ☐ MEDICATIONS ☐ BOTH

BY DOCTOR: \_\_\_\_\_ ☐ ENDO ☐ PCP ☐ PHARMACIST

LAST A1C: \_\_\_\_\_ DATE: \_\_\_\_\_ FBS: \_\_\_\_\_ DATE: \_\_\_\_\_

LAST EYE EXAM: \_\_\_\_\_

DO YOU SEE A NEPHROLOGIST (KIDNEY) DOCTOR? \_\_\_\_\_

DO YOU HAVE NEUROPATHY? ☐ YES ☐ NO

ARE YOU INTERESTED IN DIABETIC SHOES? ☐ YES ☐ NO

NOTES: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## FINANCIAL POLICY

Kaplansky Foot and Ankle Centers, would like to thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

**NO SHOWS:** There may be a Charge of \$30.00 for all no show appointments.

**INSURANCE:** All co-payments and deductible must be paid at the time of service. We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**MEDICARE:** We are a participating Medicare provider; however, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any co-payments / co-insurance, which are usually 20% of the allowed amount for an item or service.

**SELF-PAY:** Payment in full is due at the time of service if you do not have health insurance.

**NON-COVERED SERVICES:** Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

**REFERRALS / AUTHORIZATIONS:** We are required to follow the guidelines of your managed care plan, which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit.

**CLAIM SUBMISSION:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. If we participate with your Insurance we will file Insurance before billing you. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

**PATIENT BILLING:** You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and / or explanation of benefits (EOB) is received from your insurance company / companies. After the third and last notice, your account may be forwarded to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case-by-case basis. We accept the following payment methods: Cash, Check or VISA / MasterCard. An additional \$25.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.



## NOTICE OF PRIVACY PRACTICES

**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 your 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 permission:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- 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 law.

**PATIENT RIGHTS:** As our patients, you have the following 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 ask for a copy of the Notice of Privacy Practices and the name of person or persons whom you may contact.



## OFFICE POLICY

**APPOINTMENTS:** If you are unable to keep an appointment, please call the office to reschedule at least 24 hours in advance. Patients who no show/no call three appointments may be asked to transfer their records to another doctor. Patients who are 15 minutes late to their scheduled appointment may be asked to reschedule their appointment to another date and time.

Kaplansky Foot and Ankle Centers reserves the right to terminate the doctor-patient relationship for the following reasons:

**Treatment non-adherence** - The patient does not or will not follow the treatment plan.

**Follow-up non-adherence** - The patient repeatedly cancels follow-up visits or is a no-show.

**Office policy non-adherence** - The patient uses weekend on-call physicians or multiple healthcare practitioners to obtain refill prescriptions when office policy specifies a certain number of refills between visits.

**Verbal abuse** - The patient or a family member is rude and uses improper language with office personnel, exhibits violent behavior, makes threats of physical harm, or uses anger to jeopardize the safety and well-being of office personnel with threats of violent actions.

**Nonpayment** - The patient owes a backlog of bills and has declined to work with the office to establish a payment plan.



## **ASSIGNMENT OF BENEFITS, ACKNOWLEDGEMENT AND AUTHORIZATION**

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Kaplansky Foot & Ankle Centers all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and / or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I acknowledge that I was provided a copy of the Assignment of Benefits (above) and that I have read (or had the opportunity to read if I so chose) and understand the policy.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I acknowledge that I was provided a copy of the Financial Policy and that I have read (or had the opportunity to read if I so chose) and understand the policy.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I acknowledge that I was provided a copy of the Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the policy.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I acknowledge that I was provided a copy of the Office Policy and that I have read (or had the opportunity to read if I so chose) and understand the policy.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

PRINT Patient/Parent/Authorized Representative Name: \_\_\_\_\_