Balanced Podiatry Care, PLLC
30205 Schoenherr Rd # A
Warren, MI 48088

Rami Al-Rashed, DPM

New Patient Information

Patient Name:			**Address:** **City: _____ St:_____Zip:**
Gender:	**DOB:____/____/**	**Age:**	**Primary Insurance:**
Primary Doctor: **Last Visit Date:**			**Effective Date: __/__/_____Relation to insured:**
Referring Doctor:			**Secondary Insurance:**

Ethnic Group:

Not Hispanic or Latino

Hispanic or Latino

Other

Decline to answer

Race:

American Indian or Alaskan Native

Asian

Black or African American

White

Hawaiian or Pacific Islander

Other

Decline to answer

Preferred Language:

English

Spanish

Other

Contact Information: Home: ( ) _ _____-

Cell: (____)_____-_____Work: (_____)_____-

Email address:

Emergency Contact:_____Phone: (____)_____-_____Relationship:

How would you prefer to be contacted?

Phone

Mail
Email

How would you prefer to receive reminders from our office?
Home Phone
Cell Phone
Work Phone

Preferred Pharmacy:_____Location:_____Phone:

MAIL ORDER PHARMACY:

HIPAA Consent for Use and Disclosure of Your Health Information

By specifying and signing below, you are authorizing Balanced Podiatry Care, and its staff to leave a message on ananswering machine, voicemail or with a specified individual, which may include sensitive and/or protected health information.

I **Do____Do not____** authorize Balanced Podiatry Care, to leave detailed messages regarding my medical conditionor treatment on my voicemail.

Release my medical information to myself ONLY. **Initial:**

Patient Signature_____ (IF PATIENT IS A MINOR-SIGNATURE OF PARENT/LEGAL GUARDIAN)
Date

Insurance Authorization

- I authorize the release of any medical information necessary to process my claim and collect payment.
- I authorize payment of medical benefits to Balanced Podiatry Care, for services rendered when they requestthat payment be made directly to them.
- I understand that I am ultimately responsible for payment of services that are rendered to me.
- I understand that Balanced Podiatry Care, will bill my insurance company, however I am responsible for any balance that my insurance does not pay.
- I acknowledge that I am responsible for all copayments and/or deductibles.
- I am aware I am responsible for all costs associated with collection agency fees, attorney fees, and courtcosts associated with the collection of my debt if applicable.

Initial:

Physician Consent for Medical Treatment

I, the undersigned, hereby authorize and direct **Dr. Rami Al-Rashed** to treat my condition.
I hereby voluntarily consent for care encompassing diagnostic procedures and treatment by my physician, his assistant, designees or consultants, as may be necessary in the judgment of my physician. I am aware that thepractice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of the treatments or examination in this clinic. I understand that my medical record may be maintained and authorize access to persons involved in my care.

Initial:

Acknowledgement of Receipt of Notification of Privacy Practices

I have been made aware of the Balanced Podiatry Care Notice of Privacy Practices. By signing below, I acknowledge that I have been offered this notice, offered a chance to read this notice, and am aware that I can request a copy of this notice to take with me if so desired.

Initial:

HIPAA Authorization for release of Protected Health Information

If you choose to have your Protected Health Information released to another person, either verbally or in writing, please complete the information below. Initialing the below authorization will not affect your treatment at Balanced Podiatry Care, PLLC.

I,_____**,** approve Balanced Podiatry Care, PLLC, to release my health records to the individuals listed below at my request. I understand this authorization is valid for one year from this date andcan be revoked or revised at any time with written notice.

Name:_____ **Name:**_ **Name:**

Relationship:_____ **Relationship:**____ **Relationship:**

PATIENT HISTORY

This is a confidential record and will be kept in your electronic patient chart.
Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE__/___/

Social Security #___-____-

DATE OF BIRTH_/___/

(PLEASE PRINT) LAST NAME_____**FIRST NAME**_____**M.I.**

Family Doctor:

Reason for seeing the physician:

Have you been exposed to or currently have TB (tuberculosis)?	☐ **Y**	☐ **N**	
Have you received the Pneumonia Vaccine in the last 9 years?	☐ **Y**	☐ **N**	**Date**
ALLERGIES/REACTIONS TO ANY MEDICATION OR FOOD:			

LIST CURRENT MEDICATIONS *(include over the counter items)*

MEDICATION/DOSAGE

1.	6.
2.	7.
3.	8.
4.	9.

5.	10.

PAST SURGICAL HISTORY – Check previous surgeries & provide date *(If nothing marked then NONE APPLY)*

Appendectomy _____
Back Surgery _____
Bladder Surgery _____
Breast Surgery _____
Cesarean Section _____
Cholecystectomy _____
Colon Surgery _____
Coronary Artery Bypass _____
Coronary Stent _____
Kidney Stone Removal _____
Knee Replacement _____
Laparoscopy _____
Lithotripsy _____
Mastectomy _____
Cystectomy _____
Cystoscopy _____
Gastric Bypass _____
Green Light PVP
Heart Valve Replacement
___Hernia Repair
___Hip Replacement
___Hydrocele Repair
___Hysterectomy
___Nephrectomy
___Pacemaker Insertion
___Other

PAST MEDICAL HISTORY – Check any previous past medical problems *(If nothing marked then NONE APPLY)*

Anemia
Angina
Arthritis
Asthma
BPH

Diabetes 1 OR 2
(circle one)

Diverticular Disease
GERD
Gout

Migraine Headaches
Multiple Sclerosis
Myocardial Infarction
Osteoarthritis
Osteoporosis
Cancer: _____
Cerebrovascular Accident
(___Hemo ___Peritoneal)
Rheumatoid Arthritis
Chronic UTIs
Congestive Heart Failure
COPD
Coronary Artery Disease
Depression
Liver Disease
Lupus
___Hepatitis C
___Hypercholesterolemia
___Hyperlipidemia
___Hypertension
___Hypothyroid
___Seizure Disorder
Other

FAMILY HISTORY ***Indicate*** *what family member has the condition (****FATH, MOTH, SIS, BRO, DAU, SON****)*

Anesthesia Problems_____ Lung Problems
Heart Problems_____ High Blood Pressure
Kidney Disease_____ Stroke

Bleeding Disorders_____ Cancer_____ Kidney Stones
_ Diabetes_____ Other

SOCIAL HISTORY: Please Circle Answers

Marital Status:	Single	Married	Life Partner	Legally Separated
	Widowed	Divorced	Polyamorous	Unknown

Smoking Status: (please circle and answer as appropriate)

Never Smoked *Smoker, current status unknown* *Unknown if ever smoked*

Current Every day Smoker: When did you start smoking?_____Packs per day?

Current Some Day Smoker: When did you start smoking?_____Packs per day?
Former Smoker: When did you quit?_____Packs per day_____ How long did you smoke?

Do you use Smokeless Tobacco? (please circle): Yes No

Do you drink Alcohol? (please circle): Never Drank Not Anymore If Yes: How much do you drink?___per day/week
Drinking habits? *Social* *Light* *Moderate* *Excessive*

Do you use recreational drugs? (please circle): Yes No

REVIEW OF SYMPTOMS *(Please circle any symptoms you are currently experiencing)*

Constitutional:	Fever	Chills	Weight Loss
Eyes:	Blurry vision	Cataracts	Glaucoma
Ears, Nose, Mouth, Throat:	Hearing Loss	Nasal Stuffiness	Sore Throat
Cardiovascular:	Chest Pains	Swollen Ankles	Irregular Heartbeat
Respiratory:	Shortness of Breath	Wheezing	Chronic Cough
Gastrointestinal:	Abdominal Pain	Nausea/Vomiting	Change in Bowels
Genitourinary:	Incontinence	Painful Urination	Blood in urine
Musculoskeletal:	Chronic Back Pain	Chronic Neck Pain	Sore Muscles
Integumentary/Skin:	Rash	Persistent Itching	Skin Cancer History
Neurological:	Numbness	Tingling	Dizziness

Hematologic/Lymphatic:	Swollen Glands	Abnormal Bleeding	Transfusion History
Psychiatric:	Anxiety	Depression	

APPROXIMATE HEIGHT:_____ WEIGHT:

Have you had your flu shot within the last year? Yes_____Month:

No

Are you A Diabetic? Yes_____No_____IF YES what is your Hemoglobin A1C

When was your last A1C checked_____?

APPOINTMENT ATTENDANCE POLICY

We, at Balanced Podiatry Care, PLLC understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: 586-751-1288

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility ofthe patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinician's at Balanced Podiatry Care, PLLC and whenever possible, we like to fill cancelled spaces to shorten the waiting period for ourpatients.
2. If less than a 24-hour cancellation is given this will be documented as a "No-Show 24" appointment and you will becharged $25.00.
3. If you do not present to the office for your appointment or notify the office you will not be in attendance, this will be documented as a "No-Call, No-Show" appointment and you will be charged $35.00.
4. If you already have 1 "No-Call, No-Show" or "No-Show 24" appointments within a one-year time period, your 2nd "No-Show 24" appointment will be assessed a $35.00 no show fee as well.
5. If you have 2 "No-Show 24" or "No-Call, No-Show" appointments within a one-year time period, you will alsoreceive a warning letter for possible dismissal from our practice.
6. After 3 "No-Show24" or "No-Call, No-Show" Dismissal from the practice will be considered.

***You will be notified by letter if the dismissal was approved.**

I have read and understand Balanced Podiatry Care, PLLC No Show/Missed Appointment Policy and understand my responsibilityto plan appointments accordingly and notify Balanced Podiatry Care, PLLC appropriately if I have difficulty keeping my scheduled appointments.

Patient Name Date of Birth Date

Patient Signature or Parent/Guardian if minor Relationship to Patient

Staff Signature Date

Please Email this form to info@balancedpodiatrycare.com or drop it off at the office.