Kevin M. Lynch, DPM / Ryan Cantwell, DPM

Please fill out completely and sign the bottom of each page

Name (last, first, middle initial) _____ Spouse/Partner _____

Address _____

City, State, Zip Code _____

Billing Address (if different) _____

City, State, Zip Code _____

Phone #_____ Cell #_____ Work #_____

Social Security #_____ Birthdate _____ _____Male _____Female

___Single ___Married ___Partner ___Divorced ___Widowed ___Legally Separated

Email Address (please print clearly) _____

Medical Dr_____ Ph #_____ Last seen_____

Pharmacy/Location_____ Ph #_____

* * * * * * * * * * * * * * * * * All diabetic patients must complete the following additional doctor information * * * * * * * * * * * * * * * * *

Endocrinologist_____ Ph #_____ Last seen_____

Vascular Dr_____ Ph #_____ Last seen_____

Primary Insurance_____ Co pay amount_____

Policy Id_____ Relation to insured ___Self ___Spouse ___Child ___Other

Subscribers name_____ Subscribers DOB _____

Second Insurance_____ Co pay amount_____

Policy Id_____ Relation to insured ___Self ___Spouse ___Child ___Other

Subscribers name_____ Subscribers DOB _____

Other Insurance _____ Policy Id_____

How did you learn about our practice?_____

Employer _____ ___FT ___PT ___Student ___Retired ___None

What is your occupation? _____ Does it involve mostly ___Standing ___Sitting

Current foot problems? _____

How long has this bothered you? _____ Is this a result of accident/injury? ___Yes ___No

Level of pain ___1-10 (10 worst) Type of pain _____

What treatments have you tried? Have they been successful?_____

Emergency Contact Name _____ Ph # _____

Please read and sign: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician, and/or medical staff of any and all updates to the information listed above.

_____ _____ _____

Signature of Patient/Parent/Guardian Print Name Date

History

Do you smoke? ___Current everyday smoker ___Current someday smoker ___Former smoker ___Never smoked

Drink alcohol? ___Yes, everyday ___Yes, occasionally ___Rarely ___Never

Substance abuse? ___Yes, I have a current substance abuse problem Please specify:_____
___No, I have never had a substance abuse problem
___Yes, I had a past substance abuse problem Please specify: _____

Last Flu Shot _____ /_____ /_____ Pneumococcal Vaccine _____Yes _____No

Current Medications ___No known medications ___I take the following medications (please list below)

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

Allergies ___No known drug allergies ___I have the following allergies

___Ace inhibitors ___Contrast, Iv Dye, Iodinated ___Nuts ___Sulfas _____
___Aspirin ___Glutens ___Peanuts ___Tape _____
___Bee stings ___Latex ___Penicillins _____ _____
___Codiene ___Novacaine ___Statins _____ _____

Privacy Information Preferences

Do you want to be exempt from public reporting ____Yes ____No
Can we send mail to the address on file ____Yes ____No
Can we call the phone number on file ____Yes ____No
Can we leave a voicemail on machine ____Yes ____No
May we send you email reminders ____Yes ____No
Please print your email address _____
Who may we leave messages with
___Husband ___ Wife ___ Daughter ___ Son
___ Mother ___Father Other (list) _____

Medical History

___Allergies ___Blood clot ___Depression ___High cholesterol ___Skin disorders
___Alcoholism ___Blood disorders ___Gout ___Hormone therapy ___Stomach/bowel
___Anemia ___Breathing issues ___Hiv ___Kidney disease ___Stroke
___Anxiety disorder ___Cancer ___Heart disease ___Liver ___Thyroid disease
___Apnea (sleep) ___Circulation problems ___Heart murmur ___Mental illness Other_____
___Arthritis ___Cortisone treatment ___Hepatitis ___Musculoskeletal Other_____
___Asthma ___Diabetes type ___1___ 2 ___High blood pressure ___Neuropathy Other_____

Are you pregnant? ___Yes ___No Are you nursing? ___Yes ___No

Have you had any surgical procedures/any surgery on the foot/ankle please list _____

Any artificial joints? ___Yes ___No Where? _____

Do you have an artificial heart valve? ___Yes ___No

Please read and sign: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician, and/or medical staff of any and all updates to the information listed above.

_____ _____ _____
Signature of Patient/Parent/Guardian Print Name Date

Record of Written Disclosure of Health Information

I _____ hereby authorize Kevin M. Lynch, DPM / Ryan Cantwell, DPM or their staff to release any/all of my protected health information to the person(s) listed below:

Name: _____ Relationship:_____ Phone #:_____

Name: _____ Relationship:_____ Phone #:_____

Name: _____ Relationship:_____ Phone #:_____

Note: If you have additional names, please attach an additional sheet to this page.

I understand that it is my responsibility to notify in writing Kevin M. Lynch, DPM / Ryan Cantwell, DPM if I ever choose to revoke this authorization at any time.

Office Policies

All requests for forms to be completed for you, your employer, any insurance or disability etc. will require a minimum charge of $25.00 to be paid at the time of the request.

Due to new government regulations, all co-pays and deductibles must be paid at the time services are rendered.

It is very important that you provide the office with your most current insurance information prior to your appointment. Dr. Lynch / Dr. Cantwell are not providers for all insurance companies. If we are not a provider for your insurance you will be responsible your balance, at the time services are rendered.

Patient Liability for Non-Covered Services

When assignment is accepted on a claim, physicians and suppliers may bill beneficiaries for services /supplies that are denied as non-covered services, while the assignment agreement prohibits physicians and suppliers from collecting more than the Medicare allowable charge for services/ supplies, it does not prohibit billing for non-covered services/supplies. Billing for non-covered services/supplies applies to services/supplies that are normally not covered by Medicare, such as annual or routine physicals as well as services/supplies that are denied as not medically necessary.

The following are non-covered procedures/supplies that may be done in our practice and will require payment upon receipt

Afo Brace	Biofreeze	Diabetic Shoes w/wo Inserts	Mcdavid Ankle Brace	Silicone Tubing
Amerigel	Cam Walker Boot	Diabetic Socks	Medi Honey	Spenco Inserts
Ankle Sock	Cast Covers	Dr Comfort Sandals/Slippers	Metatarsal Pads	Surgical Shoes
Anodyne Slippers	Compression Socks	Gel Inserts	Nail Repair Serum	Toe Combs
Bacitracin	Custom Molded Orthotics	Heat Molded Orthotics	Night Splint	Topical Fungal Solutn
Bandaids/Gauze	Diabetic Inserts	Laser Therapy	Silicone Met/Toe Pad	U shape Pads

If any of the above procedures/supplies have been performed/dispensed it will be the financial responsibility of the patient I accept the financial responsibility for any denied procedure/service/supplies.

Consent to Treat

I/We voluntarily consent to medical treatment and diagnostic procedures provided by Kevin M. Lynch, DPM / Ryan Cantwell, DPM and associated physicians, clinicians and other personnel. I We/consent to the testing for infectious diseases and testing for drugs if deemed advisable by my physician. I/We am/are aware that the practice of medicine and surgery is not an exact science and I/We acknowledge that no guarantees have been made as to the result of treatments or examinations. I/We hearby authorize any treatment(s), agreed upon with the physician which may be deemed advisable.

Assignment of Benefits

I authorize payment of medical benefits be made directly to Kevin M. Lynch, DPM, PA for any/all services furnished by Kevin M. Lynch, DPM / Ryan Cantwell, DPM

Release of Information

I authorize the release of any medical information necessary to process claims on my behalf. I authorize any holder of medical information about me to release to the health care financing administration, its agents or other insurance carriers and all information needed to determine these benefits payable for related services.

Hippa Privacy

I acknowledge that i have received my hipaa privacy practices notice

Medication History

I authorize the doctors office to retrieve my medication history

Financial Responsibility

I acknowledge that i am financially responsible for any and all co payments, deductibles, balances and non covered services.
I have read and understand all of the above,

Patient Signature:_____ Print Name:_____ Date:_____

Witness Signature: _____ Print Name:_____ Date:_____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Guardian/Caregiver Name: _____ Relationship: _____ Date: _____

Internal Use Only

If patient or patient's representative refuses to sign acknowledgement of receipt notice, please document the date and time the notice was presented to the patient and sign below.

Presented on: Date: ____/____/____ Time: _____ By, Name: _____ Title: _____