New Patient Registration
www.podiatristofnaples.com
Fellowship - Trained Foot & Ankle Specialist
1333 3rd Ave S., Suite 504 Naples, Fl. 34102 Phone: 239-260-5181 FAX: 239-260-5183

Date: _____
Name: _____ SEX: M / F DOB: _____
Email: _____
Billing Address: _____ City: _____ State: _____ Zip: _____
Phone: Best number to reach you: _____ Alternate: _____

IF SEASONAL RESIDENT, PLEASE PROVIDE YOUR LOCAL ADDRESS:
Street Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ Relation: _____Phone: _____

Primary Care Physician: _____ Phone: _____
Date of Last Visit with Primary Care Physician:_____

Pharmacy Name: _____ Phone: _____
Pharmacy Address: _____

Who referred you to our office:
Internet / Google / Newspaper / Magazine / Family / Friend/ Other _____

Parent, Spouse or Responsible Party **(if different from patient)**
Name: _____ E-mail: _____
Address:_____ City: _____ State: _____ Zip: _____
Phone: _____ DOB: _____ Sex: M/F
Relationship to Patient:_____

MEDICAL HISTORY (Please be detailed when completing, if it's not applicable please write N/A)
Reason for today's visit: _____
Is your visit today due to an injury? Y / N
If Yes, Describe: _____
Length of symptoms or problem: _____
Pain scale (0-10) (0 being no pain and 10 being the worst): ___ / 10 or ____ No Pain
Describe Pain: aching, burning, shooting, constant, sharp, occasional, mild, moderate, severe:_____
Previous Treatments:
_____
Have You been treated by a Podiatrist or Orthopedist in the past? Y / N

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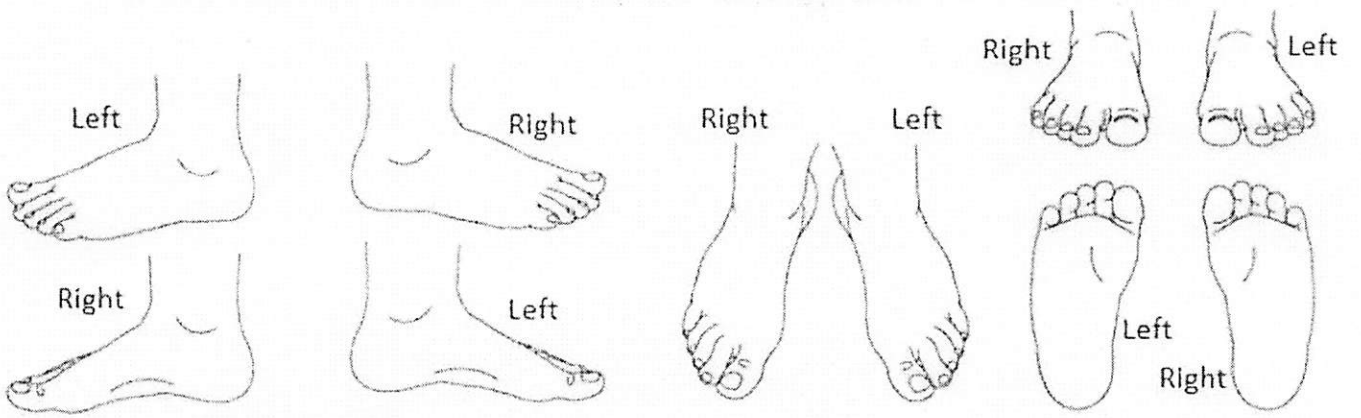
Have you had any Foot or Ankle surgeries? Y / N
Were there any complications: Y / N (Examples: wound healing problems, bone healing problems, infections, etc)
If Yes, Please explain complications: _____
Have you had complications from ANY surgeries in the past? Y / N
Do you currently wear Custom Molded Orthotics: Y / N

What would you like to accomplish at today's visit: _____
_____

SERIOUS INJURIES / ACCIDENTS (**please specify any past or current lower back problems***)
_____

Are you diabetic or pre-diabetic? Y / N If yes, last glucose reading? _____ HbA1C? _____

On diagram below, please mark the place (s) where you are experiencing pain in your feet



ALLERGIES: ☐ No Known Allergies ☐ No Known DRUG Allergies

Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____

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MEDICATIONS:

Please list ALL medications, (PRESCRIPTIONS, SUPPLEMENTS and OTC) currently being taken **(including dosage). Attach an additional sheet if necessary.**

Name of Medication	Dosage	Frequency	Reason for Medication

SURGICAL HISTORY: Please list ALL past surgeries including dates:

	DATE:

Protected Health Information

The purpose of this form is **for your convenience.** If for some reason you are unable to come in to the office to pick up a prescription or paperwork, people you list on this form are able to pick it up for you as long as identification is shown.

If you do not want to authorize anyone, please write N/A and sign/date at the bottom

I authorize Dr. Kelly Malinoski, DPM to share my protected health information with the following people:

Name: _____ Relationship: _____
Phone #: _____

Name: _____ Relationship: _____
Phone #: _____

Please note: This authorization will remain effective unless written notification is provided with changes and/or deletions.

The information I have provided is true and correct to the best of my knowledge

Signature: _____ Date: _____
Printed Name: _____

FINANCIAL POLICY

Patient's Name: _____ Date: _____

Thank you for choosing us as your health care provider. We are committed to serving you to the best of our ability. In order to bring you the quality of service, which you expect, we need to reach a mutual understanding about our payment policies. We therefore ask you to read and accept the following statement of our financial policy prior to treatment.

We accept cash, checks, Visa, MasterCard, Discover, and American Express. Please be advised if paying with a credit card a 3.5% convenience fee will be added to your total amount due.

PAYMENT IN FULL OF APPLICABLE COPAYS, COINSURANCE, OR DEDUCTIBLE ARE REQUIRED AT TIME OF SERVICE.

SELF-PAY
We expect payment in full at the time of service.

WORKER'S COMPENSATION
If you are here because of a work-related injury, we will require information regarding both health insurance and your employer's Worker's Compensation insurance. Before seeing a doctor, we will require a letter or statement from the Worker's Compensation carrier authorizing your treatment. The letter should include the claim number, address, adjuster's name and phone number. (Your employer's human resources office should be able to assist you with obtaining this information.) If payment is not received from these third parties within 90 days, we have the right to bill you directly.

PRIVATE INSURANCE
We file your insurance as a **courtesy.** Your insurance policy is a contract between you and your carrier and should have an understanding of that policy. We are not a party to that contract. Your bill with the physician is your responsibility whether or not your insurance company pays for the services rendered. You will be asked to pay the co-pay and your unmet deductible/ coinsurance at the time of your visit.

Please understand that most insurance plans do not always cover 100% of visits, procedures, etc. In the event that we are not aware of a charge or service that is not covered by your plan, you will be billed after we receive a denial from your insurance company. This also includes surgical procedures in the office and/or Surgery Center.
Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care. We assure you that what we charge is usual and customary for our area. If your insurance company refuses to accept the level of our charge, unfortunately we must still hold you primarily responsible for payment in full.

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 all services rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered. We will not become involved in a dispute between you and your company regarding deductibles, co-payments, secondary insurances, usual and customary charges or medical necessity. We will supply factual information as necessary.

MEDICARE PATIENTS
We do accept Medicare and Medicare Replacement Plans. If you do not have a secondary insurance to Medicare, we will collect 20% at the time of service.
Services that are non-covered by Medicare will require payment at the time of service.
*Medicare patients have a deductible each year. Any unmet deductible will be collected at the time of service.
*Medicare Replacement plans are not billed to Medicare but to the commercial insurance, Any copays, deductibles, coinsurances will be collected at the time of service.

MEDICAID /HMO POLICIES
NOT PARTICIPATING

MINORS

A parent or legal guardian must accompany all patients under the age of 18 to authorize treatment and financial arrangements on the account. If this is a custodial parent, we can submit the charges to another parent's insurance; however, the parent presenting the child for care will be billed for the balance not covered by the insurance. Any patient over the age of 18 will be held financially responsible for all charges incurred.

SURGERY / IN-OFFICE PROCEDURE CANCELLATION FEE

A fee of $250.00 will be charged if cancellation of a scheduled surgery is received within 2 weeks notice of that scheduled procedure.
INITIALS: _____

A fee of $200.00 will be charged if an in-office procedure is cancelled with less than 24 hours notice prior to appointment.
INITIALS: _____

CUSTOM ORDERED PRODUCTS:

You will be notified by phone when your order has arrived. You have 30 days to pick up your order, or you will be financially responsible for **all charges incurred.**

Our charge for custom molded orthotics is $550.00, which is due at the time of casting.
A **$250.00 fee** will be charged if order is canceled prior to or after shipping custom molded orthotics or custom ankle/foot orthotics for manufacturing. **NO REFUND** will be given on abandoned orthotics. **You will be responsible for the total of $550.00 for these custom molded orthotics or custom ankle/foot orthotics. If your insurance partially covers the $550 for custom orthotics, you are responsible for the difference, as custom products are a set cost, including manufacturing and supplies/shipping.**

OFFICE CANCELLATION & NO SHOW POLICY:

A fee of $100.00 will be charged if you fail to show for a scheduled appointment. A fee of $50.00 will be charged for all appointments cancelled with less than 24 hours notice from the appointment time.
INITIALS: _____

Patients who no-show to 2 scheduled appointments will receive a letter of dismissal from the practice.
INITIALS: _____

RETURNED CHECK FEE

A $75.00 charge for all returned checks. This fee will be added to your account in addition to the amount the check returned for insufficient funds. This total must be paid by cash or credit card within 14 days.

ADDITIONAL CHARGES

There is a fee of $1.00 per page for the first 25 pages and $.25 for page after 25 pages for copies of requested medical records. There is a fee of $25.00 for form completion (FMLA, Short Term Disability, etc) by patients. This fee must be paid prior to the records being copied / mailed.

A copy of X-rays on CD disk will be $25.00 and this needs to be paid at time of request.

$25.00 balance fee will be applied to your account on each unpaid statement. . Account balances exceeding 90 days will be turned over to a collection agency.

The above fees are not billable to your insurance company; therefore, these charges are patient responsibility and these services will need to be paid prior to any subsequent visits.

Financial Policy

My signature below indicates that I have read, understand, and will comply with the information contained within this financial policy. A copy of this policy is available upon request.

Signature of Patient/Guardian_____ Date____/____/____

COMMERCIAL/PRIVATE INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with_____ and assign directly to Dr. Kelly Malinoski, DPM all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electric.

Signature of Insured/Guardian_____ Date____/____/____

* * * * *

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Kelly Malinoski, DPM for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature_____ Date____/____/____

SELF-PAY PATIENTS

I, the undersigned, have read the Financial Policy of Dr. Kelly Malinoski, DPM and understand that I am financially responsible for all charges. I understand payment is due at time of service unless prior arrangements have been made.

Signature of Patient/Guardian_____ Date____/____/____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before JUNE 01, 2025.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature:_____ Date:_____/_____/____

Print Name:_____