DR GRABOWSKI PC

Name (Print legal name):_____ Male Female
Last Name First Name M.I

D.O.B: ____/____/____ **Age:**_____ **SSN**:_____ **Email**:_____

Address:_____ **Apt #:**_____
Street/PO BOX City State Zip Code

☐ **HIPPA PHONE AUTHORIZATION**: I authorize DR GRABOWSKI PC to leave messages on my voicemails in regards to information regarding appointments, treatment related issues and billing issues.

Home #:_____ Cell #:_____ ATL#:_____

HIPPA Phone Authorization other than patient: This authorization will remain in effect until you choose to revoke it in writing. I authorize, DR GRABOWSKI PC to leave messages for, or speak to the specified individual listed below in regards to information regarding appointments, treatment related issues and billing issues: (this person must provide us with your birthdate).

At my home number_____ with (name/relationship)_____

☐ **BY CHECKING THIS BOX I CONSENT TO RECEIVE PHONE CALL APPOINTMENT REMINDERS.**

Primary Physician Name: _____

Pharmacy Name: _____ **Phone #:**_____

Emergency Contact: _____

Relationship: _____ Phone #:_____ ALT #:_____

Insurance Information: Self Pay Insurance Medicare L&I Auto Other

Primary Insurance: _____ **Phone #:**_____

ID #:_____ Group # :_____

Insured's Name: _____ Insured DOB:_____ Relationship to patient:_____

Secondary Insurance:_____ **Phone #:**_____

ID #: _____ Group #:_____

Insured's Name:_____ Insured DOB:_____ Relationship to the Patient:_____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THEPHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE DR GRABOWSKI PC OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS

Patient Signature (or Parent/Guardian): _____ Date:_____

DR GRABOWSKI PC

Name:_____ DOB:_____ Weight:_____ Height:_____ Male_____ Female_____
Shoe Size:_____ Reason for today's visit:_____
Primary Language: □English □ Spanish □ Other _____ Race/ Ethnicity:□ Asian □ Black □Hispanic □White □Other

DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR THE FOLLOWING (CHECK ALL THAT APPLY)

Constitutional:
- □ Physical/Mental Cond.
- □ Addiction
- □ Anxiety
- □ Headache
- □ Major Trauma
- □ Nausea/Vomiting
- □ **No to all above**

Cardiovascular
- □ Anemia
- □ Angina
- □ Bleeding Disorder
- □ Claudication
- □ High Blood Pressure
- □ High Cholesterol
- □ Vascular Disease
- □ Phlebitis
- □ Poor Circulation
- □ Stroke
- □ **No to all above**

Endocrine:
- □ Cold Intolerance
- □ Diabetes
- □ Dry Skin/Hair
- □ Hyperglycemia
- □ Hypoglycemia
- □ Immunologic Problems
- □ **No to all above**

EYES:
- □ Glaucoma
- □ Vision Problems

Gastrointestinal:
- □ Constipation
- □ Diarrhea
- □ Heartburn
- □ **No to all above**

Genitourinary:
- □ Kidney Dialysis
- □ **No to all above**

IMMUNOLOGIC:
- □ Allergic System
- □ AIDS/HIV
- □ **No to all above**

Hematologic/Lymphatic:
- □ Ankle Edema
- □ Leg Pain
- □ Leg Swelling
- □ **No to all above**

Nervous System:
- □ Hearing Problems
- □ Neurological Problems
- □ Numbness
- □ Seizure/Paralysis
- □ Thyroid Problems
- □ Tingling

No to all above

Integumentary/Skin
- □ Athlete's Foot
- □ Cancer, Tumor, or Cyst
- □ Corn/Callouses
- □ Dermatitis
- □ Eczema
- □ Excessive Scar Tissue
- □ Fungus Nail/Skin
- □ Hives
- □ Ingrown Nail
- □ Lower Leg Ulcer
- □ Non-Healing Wound
- □ Plantar Warts
- □ Psoriasis
- □ Rash
- □ Shingles
- □ Skin Discoloration
- □ Ulceration
- □ **No to all above**

Psychiatric:
- □ Addiction
- □ Anxiety
- □ Depression
- □ **No to all above**

Social History:
- □ **Never Smoker**
- □ **Former Smoker**
- □ **Smoker: ___ Pack/day**
- □ **Alcohol:____ per week**

Muskulo-Skeletal
- □ Ankle Pain
- □ Arthralgia
- □ Arthritis
- □ Back/Neck Pain
- □ Bunion
- □ Bunionette
- □ Fibromyalgia
- □ Fracture Ankle/Toes
- □ Fractured Foot
- □ Goul
- □ Heel/Hip Pain
- □ Joint Pain
- □ Rheumatoid/Arthritis
- □ Sciatica
- □ Scoliosis

Respiratory:
- □ Asthma
- □ Bronchitis
- □ COPD
- □ Emphysema
- □ Lung Disease
- □ Sleep Apnea
- □ Tuberculosis
- □ **No to all above**

FAMILY MEDICAL HISTORY:

Medical Problem:	Relation: (ex: mom/dad)	Medical Problem:	Relation: (ex: mom/dad)
Anesthesia Problems		Addiction Type	
Arthritis		High Blood Pressure	
COPD/Emphysema		Malignant Hyperthermia	
Diabetes		Other:	

IMUNIZATION: Flu shot: Date_____ **Tetanus shot: Date**_____ **COVID vaccine: Date** _____

PRIOR SURGERIES: _____

MEDICATIONS: (PLEASE INCLUDE DOSAGE):
_____

ALLERGIES
□ NO KNOWN DRUG ALLERGIES
□ PENICILIN O ASPIRIN O SULFA O LOCAL ANESTHETIC O LATEX O ADHESIVE/TAPE O IODINE OTHER_____

SIGNATURE(OR PARENT/GUARDIAN):_____ **DATE:**_____

DR GRABOWSKI PC

PRIVACY AND CONSENT INFORMATION

This consent form is required by the Health Insurance Portability and Accountability act of 1996 (HIPPA) which requires us by law to inform you of your rights for privacy with respect to the disclosure of your health care information.

I hereby give my consent to DR GRABOWSKI PC to use and disclose my protected health information for the purpose of treatment, payment and operations of my health care and this practice

Consent for treatment: I authorize DR GRABOWSKI PC and any employee working under the direction of my physician to provide medical care for me or to the patient, which I am legally responsible for. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical and mental status/function of the body and the sale or dispensing drugs, devices, or other items required in accordance with a prescription. This content includes contact and discussion with other health care professionals for care and treatment.

Consent for Release of Information for Payment and Operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the Privacy Practice Notice.

Consent Related to the Privacy Notice: I have had an opportunity to review the Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices at any time by contacting them by phone, fax, email, or in writing. I have the right to request information on how my protected health information has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to abide by my requested restrictions, then this practice is bound to that agreement. All requests for disclosure and/or restriction must be made in writing for documentation purposes. I understand that this practice may refuse me services if I refuse to sign consent. I may revoke this consent at any time, but the practice may refuse further services at this time as well. If I revoke this consent, the revocation does not go into effect until this practice receive documented notification in writing

Consent for Assignment of Benefits: I consent to assign all payment for these services to DR GRABOWSKI PC. I understand that I am responsible for all co-payments, amounts applicable to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about services coverage. I am aware that I may be responsible for all the charges that are ensued.

Patient (or Parent/Guardian):_____ Date:_____

Please sign here

Name Printed:_____ Relationship:_____

DR GRABOWSKI PC

Our goal is to provide and maintain a good physician-patient relationship and to establish and communicate a financial policy to our patient. We are dedicated to providing the best possible care for you and we want you to completely understand our financial policy.

PAYMENT is required at time of service. We accept cash, check, or credit card (VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS).

1. On arrival, please check in at the front desk and present your current insurance card at every visit. It is your responsibility to keep us updated with your correct insurance information.

   IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPNOSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.

2. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
3. For patients with no insurance, full payment is required at the time of service.
4. While the filing of insurance claims is a courtesy that we extend to our patients, all charges not covered by your insurance company are your responsibility.
5. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
6. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
7. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 30 business days of your receipt of your bill.
8. Bills unpaid for more than 90 days may be turned over to a collection agency unless other arrangements have been made. Accounts that are turned over to collections may result in dismissal from the practice.
9. A $45.00 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
10. RELEASE OF INFORMATION: I hereby authorize and direct DR GRABOWSKI PC to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.
11. I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be occasionally amended by the practice.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

Please print the name of the patient _____

Relationship to patient: _____