10001 S Eastern Ave STE 208
Kirk D Larkin, DPM
Larkin Foot & Ankle Institute
Henderson, NV 89052
Tel: 702-623-2212 Fax:702-623-2213

Patient First Name: _____ MI: _____ Last: _____

Date of Birth: _____ Social Security#: _____ Marital Status: _____ Gender: _____

Current Mailing Address: _____ City: _____ State: _____ Zip:_____

Home Phone:_____ Work Phone: _____ Cell Phone:_____

Please check the primary number where you can be reached for medical reasons: ☐Home ☐Work ☐Cell

Email Address:_____ Ethnicity: _____ Occupation: _____ Employer: _____

Emergency Contact Name: _____ **Phone:** _____

Pharmacy Name: _____ **Address:** _____ **Phone:** _____

Primary Insurance: _____ Policy#: _____Group#: _____

Name of Insured First: _____ MI: _____ Last: _____

Date of Birth: _____ Social Security#: _____ Address:_____

Employer: _____ Relationship to Patient: _____

Secondary Insurance: _____ Policy#: _____ Group#: _____

Name of Insured First: _____ MI: _____ Last: _____

Date of Birth: _____ Social Security #: _____ Address:_____

Employer: _____ Relationship to Patient: _____

Does your insurance require a Referral? ☐YES ☐NO Was this an accident? ☐YES ☐NO

Workers Compensation claim? ☐YES ☐NO W/C Claim#: _____

Primary Care Physician: _____ **Physician's Phone:** _____

Referring Physician: _____ **Physician's Phone:** _____

Patient Name: _____ **Date:** _____/_____/_____

History & Medical Information

1. Height: _____ **2. Weight:** _____ **3. Shoe size:** _____

4. Past Medical History:

☐Anemia	☐Cancer _____	☐Heart Disease	☐Kidney Disease	☐Prostate Disorders
☐Arthritis	☐Diabetes	☐Hepatitis	☐Mitral Valve Prolapse	☐Rheumatic Fever
☐Asthma	☐Epilepsy	☐High Blood Pressure	☐Neuropathy	☐Stroke
☐Bleeding	☐Gout	☐High Cholesterol	☐Osteoarthritis	☐Thyroid Disorders

☐Other: _____

5. Allergies: (Describe reaction) ☐NONE

☐Penicillin _____ ☐Aspirin _____

☐Narcotic Agent/Codeine _____ ☐Anesthesia _____

☐Shellfish _____ ☐Sulfa Drugs _____

☐Nickel/Metal _____ ☐Radiographic Contrast Dye _____

☐Other _____

6. Are you currently pregnant? ☐ No ☐Yes

7. Surgical History: Have you had surgery? ☐ No ☐ Yes, if yes, describe below:

Surgeries:	**Date or Year:**

8. Social History: (Only check what is pertinent to you)

☐ Alcohol Use ☐ Caffeine Use ☐ Drug use (recreational, IV) ☐ Tobacco Use

9. Family History: (List of family member(s) who has or had these problems):

☐ Bleeding Disorders _____ ☐ Hypertension _____

☐ Cancer _____ ☐ Kidney Disease _____

☐ Diabetes _____ ☐ Mental Illness _____

☐ Heart Disease _____ ☐ Rheumatology _____

☐ Stroke _____

Other family History: _____

Review of Systems: (Only check what is pertinent to you)

Constitution: ☐Fatigue ☐Fever ☐Good General Health ☐Recent Weight Change
Eyes: ☐Blurred Vision ☐Double Vision ☐Eye Disease/Injury ☐Glaucoma ☐Wears Glasses or Contacts
ENT: ☐Bleeding Gums ☐Ear Aches ☐Hearing Loss ☐Mouth Sores ☐Nose Bleeds ☐Sinus Problems ☐Sore Throat ☐Swollen Neck Glands ☐Tinnitus ☐Voice Change
Cardio: ☐Angina ☐Chest Pains ☐Heart Attack ☐Hypertension ☐Palpitations
Respiratory: ☐Asthma ☐Coughs ☐Shortness of Breath ☐Spitting Blood
Gastro: ☐Abdominal Pain ☐Change in Bowel Movements ☐Diarrhea ☐Heartburn ☐History of Rectal Bleeding ☐History of Stomach/Duodenal Ulcers ☐Loss of Appetite ☐Nausea ☐Vomiting
Musculo: ☐Back Pain ☐Difficulty Walking ☐Joint Pain ☐Muscle Cramps ☐Muscle Weakness ☐Stiffness
Neuro: ☐Convulsions ☐Dizziness ☐Frequent Headaches ☐Head Injury ☐Lightheadedness ☐Numbness ☐Paralysis ☐Seizures ☐Stroke ☐Tingling Sensations ☐Tremors
Psychiatric: ☐Depression ☐Insomnia ☐Memory Loss ☐Nervousness
Endocrine: ☐Cold Intolerance ☐Diabetes ☐Glandular Problems ☐Heat Intolerance ☐Hormone Problems ☐Thyroid Disease
Hematologic: ☐Anemia ☐Bleeding Tendencies ☐Enlarged Glands ☐Past Transfusions ☐Phlebitis ☐Slow Healing After Cuts
Immunological: ☐Hepatitis A ☐Hepatitis B ☐Hepatitis C ☐HIV ☐Tuberculosis

CONSENT TO TREATMENT

I hereby give permission for Kirk D. Larkin, DPM to examine and render medical and/or surgical treatment, and to provide to referring/consulting physician, insurance companies, their representatives, or my attorney, information they may require regarding my condition while under treatment. I also agree to follow ALL prescribed treatment. I authorize photographs to be taken for medical education purposes. I also authorize the release of any information required or acquired in the course of examination or treatment.

☐ I consent to treatment.

Patient Name (Please Print) _____

Signature of patient or parent if a minor or responsible party _____

MEDICARE AUTHORIZATION, If Applicable Please Sign I request that payment of authorized Medicare benefits be made either to me or on my behalf to Larkin Foot and Ankle Institute for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in the item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing 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 service. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ **Date** _____

LIST CURRENT MEDICATIONS/ VITAMINS- List dosage. Attach a separate list if necessary. ☐NONE

Medication	**Dosage**

Patient Financial Agreement

Dear Patient:

We would like to take this opportunity to welcome you to our practice and thank you for choosing Kirk D. Larkin, D.P.M. to provide your foot and ankle care. We appreciate your trust and look forward to keeping your feet and ankles healthy. As part of your service, we try to contain the rising cost of healthcare. In an effort to do this, we have implemented this Financial Policy, which we ask you to read and sign. You may receive a copy for your records if you so desire.

INSURANCE BENEFITS AND COVERAGE As a courtesy to you, our billing service will submit your insurance claim(s) for treatment rendered at this office. Please be advised that your insurance policy is a contract **between you and your** insurance company. We **are not** a party to that contract. If you ever have any questions regarding your coverage and /or benefits, please contact your insurance company. Ultimately, you are responsible for all costs incurred during treatment with the exception of insurance contracted adjustments. These adjustments are determined by the contract with the doctor and the insurance company. If your insurance does not accept assignment of benefits, in other words, if they pay you rather than the doctor, payment must then be made in full at the time of service. In such instances, we will submit the claim on your behalf.

COPAYMENTS, DEDUCTIBLES, AND COINSURANCE Although, we do accept assignment of insurance benefits, we require payment of any copayments due at the time of service. **We accept cash, checks, and credit/debit cards.** If you have any deductible or coinsurance amounts to be met, you will be billed once your insurance has processed and paid their portion of the claim.

UNINSURED PATIENTS AND NON-COVERED BENEFITS Full payment is due at the time of service. **We accept cash, check, debit, and credit cards.** In some instances a payment plan may be made for some patients on a case-by-case basis with our billing service. While we try to accommodate all of our patients, our billing service does maintain strict guidelines regarding payment plans.

BALANCE AND STATEMENT You will receive a statement once a month only if you have a balance owing. **Failure to pay a balance by the third billing statement will result in your account being turned over to "collection status."** The doctor will no longer be able to continue treatment until the balance is paid or special payment arrangements are made. **Please note that there is a $25 fee plus balance on all returned checks.** In order to refrain from raising our fees, we must control our costs and maintain efficiency in the business aspect of our practice. We are dedicated to providing you and your family with the best possible podiatric care. We will also attempt to accommodate you whenever possible. If you have any questions, please contact our office and we will be happy to discuss them with you. Thank you for your understanding.

NO SHOW/CANCELLATION POLICY If you need to cancel/reschedule your appointment, **we require 24 hours' notice**, so we can schedule another patient who is in need of medical care. You are required to call **702-623-2212** to cancel your appointment. If your appointment isn't cancelled, you will be assessed a **$45 penalty fee.** Repeated no shows may result in discharge from Larkin Foot & Ankle Institute. By signing below, you acknowledge and understand our no show/cancellation policy. If you have any questions and/or concerns, please contact our office. We thank you for your understanding regarding this matter and appreciate your cooperation.

I have read the Financial Policy and understand and agree to its terms.

Patient Name (Please Print) _____

_____ _____

Signature of patient or parent if a minor **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

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

_____

Patient Name (Please Print)

_____

Parent or Guardian Name (Please Print)

_____ _____

Signature of patient or parent if a minor **Date**