THE FOOT CARE INSTITUTE OF MICHIGAN

AUTHORIZATION FOR PAYMENT

I authorize use of this form on all my insurance submissions.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

I authorize payment directly to my doctor.

Payment is subject to the terms of your insurance policy and can only be determined at the time the claim is processed. If, for any reason, the carrier denies your claim, you accept responsibility to pay the entire balance or any remaining balance .

Print Name:_____

Signature:_____ Date:_____

THE FOOT CARE INSTITUTE OF MICHIGAN

The Foot Care Institute of Michigan
Macomb Professional Bldg.
11885 E. 12 Mile Road, Suite 202B
Warren, MI. 48093
586-755-4242 phone
586-755-6231 fax

The Foot Care Institute of Michigan
11650 Belleville Rd.
Belleville, MI. 48111
734-699-2400 phone
734-699-3669 fax

The Foot Care Institute of Michigan
21111 MiddlebeltRd.
Farmington Hills, MI. 48336
248-478-1150 phone
248-478-1156 fax

Please Print

Is your appointment with (circle one)

Charles R. Young, DPM Marshall G. Solomon, DPM Jeffrey Y. Yung , DPM Susan P. King, DPM

PATIENT INFORMATION

Name: _____
Last First Middle Initial

Mailing Address:_____

City:_____ State:_____ ZIP:_____

Phone#_____ 2nd No._____3rd No._____

DOB:_____ Gender: Male Female SSN:_____

Marital Status: S M W D If insurance is in spouse's or parent's name, what is their date of birth_____

Family Physician:_____ Phone #:_____

Email Address:_____

I hereby give my permission to Drs. Young/Solomon/Yung/King to administer such procedures as may be deemed necessary in the diagnosis and treatment of my foot condition. Furthermore, I acknowledge that I am fully responsible for all deductibles or portions of medical expenses not covered by my insurance company.

Date_____Signature_____Relationship_____

THE FOOT CARE INSTITUTE OF MICHIGAN

MEDICATION LOG

Patient ___________________________________Birthdate_______________________

Phone No.____

Pharmacy___________________________ Phone No.___________________________

DATE	MEDICATION	DOSAGE	QTY	FREQ

THE FOOT CARE INSTITUTE OF MICHIGAN

DR. CHARLES YOUNG DR MARSHALL SOLOMON
DR JEFFREY YUNG DR SUSAN KING

Many of the causes of foot discomfort are due to linked motion, muscle or ligament strain. Weak foot structure causes foot discomfort when the bones and joints cannot function correctly. Over time pain may develop.

The casting to obtain an impression of the feet, the orthotic and all lab fees are included in the cost of the orthotic. These fees are:

Initial pair_____$425.00

2nd pair (as long as the lab has the case molds and nothing has changed)
$325.00

Refurbishing of orthotics_____$45.00

Note: Dispensing orthotics, x-rays, future examinations and further testing, if necessary, are NOT included in the cost of the orthotics.

ORTHOTICS ARE CUSTOM MADE AND ARE NON-REFUNDABLE AT THE TIME OF SERVICE (CASTING, MEASURMENT).

Every effort will be made to make these orthotics work for you. The first follow-up visit is very important. At that time, adjustments, if necessary, will be made.

In the past, we have found that many insurance companies do not provide complete coverage for custom foot orthotics. Many find them not medicallynecessary. If we are a participating provider with your insurance plan, we will contact them for a quote of benefits. We will require a minimal down payment of 50% of your quoted responsibility at the time of casting. However, participation in your plan or quoted benefits are not guarantee of payment. Payment is subject to the terms of your policy and can only be determined at the time the claim is processed. If your insurance company says orthotics are an exclusion on your policy, we will not bill your insurance.
By signing below you are accepting responsibility for the entire cost of the orthotics regardless of quoted benefits.

If for any reason you insurance carrier denies the orthotics, you agree to pay the entire balance or any remaining balance. This includes any deductibles and/or denial of the orthotics.

_____ _____

Patient Signature Date

THE ORTHOTICS ARE NOT RETURNABLE FOR A REFUND OR CREDIT

PLEASE CHECK ALL THAT APPLY WITH

F FOR FAMILY OR **S** FOR SELF

__High Blood Pressure
__Fainting/Dizzy Spells
__High Cholesterol
__Heart Attack
__Hemophilia
__Heart Disease
__Dizziness
__Extremities Cold
__Pace Maker
__Poor Circulation
__Rheumatic Fever
__Stroke/CVA
__Swelling of feet
__Varicose Veins
__Blood Clots

__Asthma
__COPD
__Persistent Cough
__Shortness of Breath
__Sleep Apnea
Snoring
__Tuberculosis
__Allergies/Hives

__Glaucoma
__Cancer
__Diabetic Type I
__Diabetic Type II
__Fatigue
__Goiter
__Gout
__Hypoglycemic
__Increased Hunger
__Increased Urination
__Thyroid Disease
__Weight Loss
__Black Stool
__Constipation
__Diarrhea

__Liver Disease
__Poor Appetite
__Stomach Ulcer
__Vomiting Blood
__Frequent Urination
__Kidney Disease
__Corns/Calluses
__Deformed Nails
__Infected Nail
__Ingrown Nail
__Skin Cancer
__Skin Disease
__Skin Lesion/Rash
__Skin Ulceration

__Thick Nails
__Ankle Sprain
__Arthritis
__Broken Bones
__Bunion/HAV
__Bursitis
__Hammer Toes
__Joint Stiffness
__Cramping w/walking
__Foot Pain
__Heel Pain
__Low Back Pain
__Muscle Pain
__Osteoporosis

__Pain w/standing
__Painful Toes
__Alzheimer's
__Burning Pain
__Dementia
__Epilepsy/Seizures
__Pins/Needles
__Numbness

__AIDS
__Anemia
__Bleeding Disorder
__Fever/Chills
__Hepatitis A
__Hepatitis B
__Hepatitis C
__HIV
__Anxiety
__Depression
__Paranoia

The Foot Care Institute of Michigan
Medical History

Height_____ Weight_____ Shoe Size_____ Age_____

Please describe your foot problem(s)_____

_____

Have you been under the care of a medical doctor in the past two years? YES_____ NO_____

If so, why?_____

_____

Primary physician's name_____Phone number_____

Allergies:_____

_____

Do you smoke? Y_____ N_____ Drink alcohol: Y_____ N_____ How often?_____

Recreational drug use? Y_____ N_____ Do you bruise or bleed easily? Y_____ N_____

WOMEN: Are you currently pregnant? Y_____ N_____

List all previous surgeries and complications:_____

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or medications I will inform the doctor at my next appointment.

Date_____ Name (please print)_____

Signature_____