METRO VANCOUVER PODIATRY

Helping You Put Your Best Foot Forward

3185 Grandview Hwy
P: 604-434-2222
F: 604-434-2220

6184 Fraser St.
P: 604-301-9955
F: 604-301-1566

2032 Kingsway
P: 604-874-5555
F: 604-874-5255

WELCOME TO OUR OFFICE! Please take a moment to complete this form to the best of your ability.

Last Name	First Name	Prefer to be called
Address	**City**	**Postal Code**
Date of Birth (MM/DD/YYYY)	☐ Female ☐ Other ☐ Male _____	**Care Card Number**
Phone Number	**Alternate Phone Number**	**How did you hear about us?**
E-mail Address		**Occupation**
Emergency Contact	**Relationship**	**Phone Number**

Family Doctor: _____ **City:** _____ **Phone number:** _____

Have you seen a podiatrist before? Yes **Podiatrist Name:** _____ **Date of Last Visit:** _____

Reason for Today's Visit: _____

MEDICAL HISTORY Height: _____ **Weight:** _____ **Shoe Size:** _____

Please Indicate if you have / had any of the following:

- ☐ Angina / Chest Pain
- ☐ Anxiety
- ☐ Artificial Heart Valve (date: _____)
- ☐ Artificial Joints (specify: _____)
- ☐ Arthritis (type: _____)
- ☐ Asthma
- ☐ Back problems
- ☐ Cancer (type: _____)
- ☐ Circulation problems
- ☐ Depresion
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart disease (specify:
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Pregnant (currently)
- ☐ Stomach Ulcers
- ☐ Stroke (date: _____)
- ☐ Thyroid problems

Do you have DIABETES: ☐ Yes ☐ No
If yes, what type? ☐ Type I ☐ Type II
Are you on: ☐ Oral medication ☐ Insulin

Do you have prolonged bleeding after a cut?
☐ Yes ☐ No

Any family history of bleeding disorders?
☐ Yes (specify: _____) ☐ No

Are you taking blood thinners? ☐ Yes ☐ No
If yes, what: _____ Reason: _____

Have you ever had a clot in your leg or lungs?
☐ Yes (where/when: _____) ☐ No

Have you ever been tested for HIV?
☐ Yes: i'm positive ☐ Yes: i'm negative ☐ No

Have you ever had hepatitis?
☐ HepA ☐ HepB ☐ HepC ☐ None

Do you have trouble healing wounds?
☐ Yes ☐ No

Do you smoke?
☐ Yes ____ cig/day for ____ yrs
☐ Quit in
☐ No

Alcohol use:
☐ Regular
☐ Occasional
☐ Never

Please list any other major illnesses or injuries in last five years:

Please list any allergies:

- ☐ Adhesive tape
- ☐ Aspirin
- ☐ Iodine
- ☐ Local anesthetics
- ☐ Latex
- ☐ Metal
- ☐ NSAIDs
- ☐ Penicillin
- ☐ Shellfish
- ☐ Sulfa

Other, please specify:

_____

Current medications
(including over the counter)

Please list any previous surgeries
(include dates when possible)

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Patient Last Name: _____ **Patient First Name:** _____ **Patient Personal Health Number (PHN):** _____

Please read and acknowledge the following by signing below:

1) **Fee for services:**
I understand that BC Medical Services Plan (MSP) does not cover all podiatry services. I understand that payment methods for services are: cash, interact/debit, Visa or Mastercard and are due at the time of service. For benefits that are partially covered by MSP you will only be charged the portion that MSP does not pay. Similarly for patients with coverage for supplementary benefits we will deduct the MSP portion from what you will pay.

2) **Authorization for Payment from MSP to Opted-Out Practitioners:**
I, the patient named above, authorize MSP to pay the practitioner named below directly for reimbursements for benefits payable to me under the Medical and Health Care Services Regulation for care provided to me. I authorize the practitioner to collect MSP payment from the date when this form is signed to the end of the calendar year in which this form is signed. For each service provided, the practitioner will notify me of the full fee and what portion of the fee they will claim directly from MSP. IF I qualify for supplementary benefits, I am aware that MSP contributes $23 per visit for a combined annual limit of 10 visits each calendar year for the following services: acupuncture, chiropractic, massage therapy, naturopathy, physical therapy and non-surgical podiatry. For other services (eg surgical podiatry) MSP contributes an amount in accordance with the relevant payment schedule. I make this authorization in full knowledge that the practitioner will receive the full amount that is reimbursable to me from MSP for this service, and that I will not receive further reimbursement from MSP for any monies I have paid for this service (if applicable)

3) **Appointment Policy**
I understand that once i make an appointment both time and space have been reserved for me. If I fail to give a minimum 48hours notice to cancel or reschedule an appointment, or if I do not show up for a reserved appointment time I understand that I will be charged a cancellation or no-show fee of $45. This policy allows for mutual consideration of both yours and the physician's time.

Patient Signature:_____ **Date Signed:** _____
If patient is under 19 or otherwise unable to make decisions on their own parent or legal guardian may sign and indicate below:
Name of Individual Signing above: :_____ **Relationship to patient:**_____

PRACTITIONER INFORMATION AND DECLARATION :

Practitioner Name: AMANDEEP K. RANDHAWA **MSP Practitioner Number:** 60157 **MSP Payment Number:** 60157

Practitioner Declaration: I have advised the patient that this form allows me to receive MSP reimbursement directly for services that are MSP benefits, and that the patient will not receive further reimbursement from MSP. I acknowledge that all claims for services provided to this patient comply with the *Medicare Protection Act* and the relevant payment schedule. For each service provided, I will notify the patient of the full fee and what portion of the fee I will be claiming directly from MSP. I understand that this authorization is only valid for the remainder of the calendar year in which it is signed, and that the patient and I must complete a new Authorization for Payment from Medical Services Plan to Opted-Out Practitioners Form prior to directly billing MSP in future calendar years. Further, I understand that eligible patients are only eligible for supplementary benefits for 10 claims per year for all supplementary services. As such, if the service relates to a supplementary benefit, I know that I will only receive reimbursement from MSP if the patient has eligible claims remaining for the year on the date of claim submission.

Practitioner Signature:_____**Date Signed:**_____