



10161 Dr. Jeffery Szczepanski
E. Pickwick Ct. Ste E., Traverse City, MI 49684

Welcome to Great Lakes Foot & Ankle Specialists, PLLC

Phone: (231) 935-8800

Fax: (231) 935-8801

The following is information that you will find helpful as you join our practice:

- We provide you with convenient 24/7 access to your medical records from the privacy of your computer or smart phone through our **Patient Portal or Healow App**.
- We want to make sure you receive well-coordinated, effective care that addresses your concerns, and respects your wishes.

First Visit: print new patient intake forms by visiting www.greatlakesfoot.com, click the New Patient tab, and scroll down and print the hyperlink to obtain our new patient forms for completion ahead of your visit.

- **Bring your insurance card(s) which are required at every visit.**
- **Bring your completed new patient forms.**
- **Bring your driver's license or photo ID.**
- **Bring your current prescription bottles, or updated medication list, so we can record them accurately.**
- **Bring active insurance and contact your insurance company regarding copays, co-ins and deductibles. Copayments & balances must be paid at time of service.**

Our Location and Hours:

- Address: 10161 E. Pickwick Court, Ste. E, Traverse City, MI 49684
- GLFAS Office Hours: Monday – Thursday 8am – 5pm, Friday 8am-12pm (closed 12pm-1pm)
- Sole Med Spa Hours: Wednesday's 9am - 3pm & Friday's 9am – 12pm

Scheduling: **Great Lakes Foot & Ankle Phone: 231-935-8800 ~ Sole Med Spa Phone: 231-709-4121**

- To request, or reschedule and appointment, please press 2.
- If you are in need of a prescription refill, please press 3.
- To speak with a clinical staff member, please press 4.
- To reach our surgery coordinator, please press 5.
- To reach Sole Med Spa, please press 6.
- To reach our billing representative, please press 7.
- To reach our practice manager, please press 8.

After Hours:

- If you are experiencing a medical emergency, please call 911 or go to your nearest emergency room.
- If you have an urgent need outside of business hours, please page Dr. Szczepanski at 231-935-8800 *

Prescription Refills:

- Please try and request prescription refills during your office visits.
- You can place prescription refill requests through your patient portal or by calling 231-935-8800 press 3.
- Refill requests should be placed 72 hours (three days) in advance.

Financial Arrangements:

- See our Financial Policy for complete details.
- Charges not covered by your insurance are due at the time of service.
- You are fully responsible for any portion of your bill that is denied or otherwise not paid by your insurance carrier.
- To request a payment plan, please call our billing representative directly at 231-714-0642.
- Once a claim has been sent to your insurance company, we will not change the billing.



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GLFAS Financial/Billing Agreement

- **Payment is due at the time of service.** We accept cash, checks, money orders, and all major credit cards. Our billing office will work with you to set up a payment plan, if necessary. We charge \$25 for checks returned due to insufficient funds or closed accounts.
- **Insurance cards must be presented at your first appointment and if you have received a new card since your previous visit.** It is your responsibility to know what services your insurance will cover and what your cost share will be. If our records do not show a copay is owed but you know that you have a copay for specialist visits, please let us know and we will update our system accordingly.
- **No Insurance Coverage/Self Pay:** Payment is due at the time of service.
- **No Show Policy:** We require **24-hour notice** to cancel or reschedule your appointment or surgery. Failure to do so will result in the following fees being billed to you.
 - **\$30** for office visits that are cancelled with less than 24-hour notice.
 - **\$50** for missed/no-show appointments without calling prior.
 - **\$50** for in-office procedures that are cancelled with less than 24-hour notice.
 - **\$250** for any outpatient surgical procedures that are cancelled with less than 24-hour notice.
 - These fees are **NOT** reimbursable by your health insurance and will be payable by **YOU** directly
- **Repeated no-shows result in a discharge from care.**
- **The patient (or parent of minor children) is fully responsible for any portion of their bill that is denied, or otherwise not paid, by their insurance carrier.**
- **I authorize payment to be made directly to my physician and/or Great Lakes Foot & Ankle Specialists (GLFAS).**
- **I understand that I am financially responsible for fees not paid by my insurance company.**
- **I agree to the terms of this financial agreement.**

Patient Signature: _____ Date: _____

Patient Name: _____ DOB: _____



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www.GreatLakesFoot.com

DR. JEFFREY A. SZCZEPANSKI
10161 E Pickwick Ct. Suite. E, Traverse City, MI

Today's Date ____/____/____

Patient Information	<p>Patient Name _____ <small style="margin-left: 100px;">First</small> <small style="margin-left: 150px;">Middle</small> <small style="margin-left: 150px;">Last</small></p> <p>Date of Birth _____ Social Security Number _____</p> <p>Mailing Address _____ <small style="margin-left: 450px;">City</small> <small style="margin-left: 100px;">State</small> <small style="margin-left: 100px;">Zip Code</small></p> <p>Physical Address _____ <small style="margin-left: 450px;">City</small> <small style="margin-left: 100px;">State</small> <small style="margin-left: 100px;">Zip Code</small></p> <p>HOME Phone _____ CELL Number _____ May we leave a detailed message at home? () Yes () No May we leave a detailed message on cell? () Yes () No</p> <p>EMAIL _____</p> <p>Primary Health Insurance _____</p> <p>Policy Number _____ Group Number _____</p> <p>Advantage Plan/Secondary Health Insurance _____</p> <p>Policy Number _____ Group Number _____</p> <p>Responsible Party (if other than parent/spouse) _____</p> <p>Patient is () Single () Married () Widowed () Separated () Divorced</p> <p>Emergency Contact _____ Relationship _____</p> <p>Emergency Contact Phone _____ <input type="checkbox"/> <i>Please check if we may release information</i></p> <p>Employment Status () Employed () Not employed () on Temporary Leave () Retired</p> <p>Employer Name _____</p> <p>Work Number _____ Job Title/Description _____</p> <p>Whom may we thank for referring you to this office? _____ Relationship _____</p>
Primary Care	<p>Primary Care Provider _____</p> <p>PCP Address _____ <small style="margin-left: 450px;">City</small> <small style="margin-left: 100px;">State</small> <small style="margin-left: 100px;">Zip Code</small></p> <p>Phone Number _____ Date Last Seen _____</p>
Foot/Ankle Issues	<p>Please describe your primary foot problem _____</p> <p>How long has it been bothering you? ____ Days ____ Weeks ____ Months ____ Years</p> <p>Have you been treated for this problem () Yes () No If yes, when and what was done? _____</p> <p>_____</p> <p>Have you treated this problem at home? () Yes () No If yes, how? _____</p> <p>_____</p> <p>Have you injured your feet/ankles before? _____</p> <p>_____</p> <p>Have you had imaging (X-rays, Bone Scans, MRI) done in the last 3 months on the affected area(s)? () Yes () No If yes, what facility? ____ Munson Healthcare ____ Novello ____ Other _____</p>

Turn over to continue



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Medical History

What kind of work do you do? _____

Most Recent Height _____ Weight _____ Shoe Size _____

Are you in () Good Health () Fair Health () Poor Health

Are you subject to prolonged bleeding or healing difficulties? _____

I have (or) have had the following:

___ Anemia ___ Blood Clots ___ Gout ___ HIV/AIDS ___ Low Back Pain

___ Arthritis ___ Cancer ___ Hepatitis ___ Joint Replacement ___ Polio

___ Asthma ___ Diabetes ___ Heart Trouble ___ Kidney Trouble ___ Poor Circulation

___ Bleeding Tendencies ___ Epilepsy ___ High Blood Pressure ___ Leg Cramps ___ Stroke

Explain any of the above conditions you have had _____

Has any FAMILY member had Diabetes, Cancer, Heart Disease, or other serious conditions? If yes, please list relation and condition(s) _____

Are you pregnant? () Yes () No

Do you exercise? () Yes () No If yes, how often? _____

Do you smoke? () Yes () No If yes, how much? _____

If you quit, when did you quit? _____ How long did you smoke? _____

Have you had a drink containing alcohol in the past year? () Yes () No

If yes, how often? ___ Once a month or less ___ 2-4 times a MONTH ___ 2-3 times a WEEK ___ 4 or more times a WEEK

Do you use Marijuana? () Yes () No If yes, how often? _____

Do you have current or past illicit drug use/abuse? () Yes () No If yes, explain _____

Have you fallen in the last year? () Yes () No How many falls? _____

Were you injured? () Yes () No Describe Injuries _____

Do you have an Advanced Directive or Living Will? () Yes () No

Please list all hospitalizations and surgeries (and surgical dates) you've had that are related to your foot and ankle conditions _____

Medications and Allergies

List all Medications and the dosage _____

Name of your Pharmacy _____ Location _____

() I am not allergic to anything to my knowledge.

() I am allergic to (Check all that apply):

___ Adhesive Tape ___ Codeine ___ NSAIDS ___ Lidocaine/Local Anesthetic ___ Surgical Metal

___ Sulfa ___ Iodine ___ Penicillin ___ Other _____

Please explain the type of "Allergies" reaction you have had _____

Please sign below that you have reviewed the information above, and it is correct to the best of your knowledge. By signing you are also consenting to treatment at Great Lakes Foot & Ankle.

Signature of Patient or Guardian

Date