Foot & Ankle Centers

Centers for Foot & Ankle Surgery, Ltd.

Welcome and thank you for choosing our practice. We put your feet first!

First Name_____ MI_____ Last Name_____ ❍Male ❍ Female

Patient Date of Birth_____/_____/_____ Age_____ Social Security Number _____-_____-_____

***If patient is a minor** – provide name of parent(s) or guardian _____

Marital Status: ❍ Single ❍Married ❍ Widowed ❍ Divorced ❍Spouse/Partner Name:_____

Patient Home Street Address_____ Apt#_____

PO Mailing Address [if applicable] _____

City_____ State_____ Zip _____

Primary Contact number: ❍ Cell ❍ Home (Please provide TWO forms of Contact we request two contact numbers)

Cell phone# _____ Home _____

Work: _____ Other:_____

Emergency Contact Name_____Ph#_____Relationship_____

Patient's email (print)_____e-*mail address is for **internal** use only.*

Patient Occupation_____ Employer Name_____

Employer Address_____

Address/ph# of parents or guardian (if different from above): _____

Cell ph#: _____ Other Ph # _____

Preferred Language: ❍ English ❍ Spanish ❍ Other _____

PAYMENT AND INSURANCE INFORMATION

❍ Self Pay (*Our Practice is <u>not</u> a Medicaid provider and <u>cannot</u> bill Medicaid)*

PRIMARY insurance: _____ Full Name of Insured _____ Relationship to Patient_____

Insured SS_____-_____-_____ Insured Date of Birth _____ /_____/_____

Insured Employer _____ Address_____

SECONDARY insurance: _____ Full Name of Insured _____ Relationship to Patient_____

REFERRAL INFORMATION

How did you hear about our office?

❍ Google ❍ Newspaper Ad ❍ Saw our Sign ❍ Insurance Plan ❍ Our Website ❍ Yorkville Theatre ❍ Morris Theatre
❍ Facebook Yorkville's Moms Group ❍ Facebook ❍ Twitter ❍ LinkedIn ❍ Hospital ❍ Phone Book ❍ Other _____

❍ Doctor Name_____ Ph #_____

❍ Family Member ❍ Friend Name_____ Address_____

Please continue on the next 3 pages

MEDICAL HISTORY

Do you drink? ❍No ❍ Yes Drinks per week _____

Do you smoke? ❍No ❍ Yes Packs per day _____

Have YOU ever had any of the following **foot conditions**?

Please check all which apply:

- ❒Ankle Instability
- ❒ Arthritis
- ❒ Back Pain
- ❒ Blisters
- ❒ Bone Spurs
- ❒ Bunions
- ❒ Burning Feet
- ❒ Corns/Calluses
- ❒ Diabetic Evaluation
- ❒ Flat Feet
- ❒ Fracture
- ❒ Fungal Infections (skin/nail)
- ❒ Gout
- ❒ Hammertoes
- ❒ Heel Pain
- ❒ Hip Pain
- ❒ Infections
- ❒Ingrown Toenails
- ❒ In Toe – Out toe walking
- ❒ Joint Pain
- ❒ Knee Pain
- ❒ Limb Length Discrepancy
- ❒ Neuromas
- ❒ Numbness/tingling in foot or toes
- ❒ Plantar Fasciitis
- ❒ Postural Fatigue
- ❒ Pronation
- ❒ Shin Splints
- ❒ Sprains
- ❒ Sweating/Odor
- ❒ Tendonitis
- ❒ Tired feet
- ❒ Ulcers
- ❒ Warts

Have YOU ever been treated for any of the following conditions?

Please enter ✓ if it applies to **YOU**

Enter **M** if on your mother's side - **F** on your father's side

- _____Acid Reflux
- _____Anemia
- _____Arthritis
- _____Asthma
- _____Bleeding Disorders
- _____Cancer
- _____Depression
- _____**Diabetes**
- _____Epilepsy
- _____Fatigue
- _____Fibromyalgia
- _____Headaches
- _____Heart Condition
- _____Hepatitis
- _____High Cholesterol
- _____HIV/Aids
- _____Hypertension
- _____Hyperthyroidism
- _____Hypothyroidism
- _____Irritable Bowel Syndrome
- _____Kidney Problems
- _____Liver Disease
- _____Low Blood Pressure
- _____Nervous Disorder
- _____Muscle or Joint Pain
- _____Peripheral Arterial Disease
- _____Parkinson's Disease
- _____Phlebitis
- _____Poor Circulation
- _____Respiratory Disease
- _____Rheumatic Fever
- _____Shortness of Breath
- _____Seizure Disorders
- _____Stomach Ulcers
- _____Stroke
- _____Varicose veins

ALLERGIES

Have YOU ever had any ADVERSE side effects, rash, allergic Reaction to:

	YES	NO		YES	NO
Adhesive Tape			**Metal/Jewelry**		
Anticoagulants			Novocaine		
Anti-inflammatory Meds			Peanuts		
Aspirin			Penicillin		
Codeine			Seafood		
Cortisone			Other antibiotics		
Iodine			Other pain medication		
Latex			**Other** _____		

Height _____' _____"

Shoe Size_____

Please list all surgeries Please use the BACK of this page if needed	Approximate Date

MEDICATIONS

Provide a printed list or enter below

Are you currently on Blood Thinners? Yes ❍ No ❍

Medication	Dose

FAMILY / PRIMARY CARE PHYSICIAN

Name: _____

Phone: _____

PHARMACY

Name: _____

Phone: _____

CONSENT for Treatment/Authorization for payment

I consent to examination, treatment and other services provided by the doctors, their associates, or physical therapy staff. I authorize Centers for Foot & Ankle Surgery, Ltd. to release to my insurance company or its representatives, any information regarding my diagnosis or records of treatment or examination rendered to me required to process my claims.

I authorize and request my insurance company pay Centers for Foot & Ankle Surgery, Ltd. directly the amount due me in pending claims for medical treatment or services, by reason of such treatments or services rendered to me until revoked in writing. I understand I am directly responsible for services rendered and not paid by insurance.

* I understand the information provided on this form is true and correct to the best of my knowledge.

Patient Signature_____

Date _____If not patient, relationship _____

Financial Policy Agreement

We participate in most insurance plans, including Medicare. **We are not participating providers for Medicaid plans**. If you are not insured by a plan we participate with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

1. **Proof of insurance**:
   - A copy of a valid insurance card and a valid photo ID. Failure to provide us with the correct insurance information will require us to transfer the balance to you.
   - HMO: patient is responsible to request and provide us with a referral.
   - If your insurance changes, you must notify us before your next visit.

2. **Co-payments/deductibles:** must be paid at the time of service. Services you receive may not be covered by Medicare or your insurance company. Services not covered become the patient responsibility.

3. **Claims submission:** We will submit your claims and assist you to help get your claims paid. Your insurance company may need certain information directly from you, and it is your responsibility to comply with their request. The balance of your claim is always your responsibility.

4. **Cancellation/No show fees**: If you are unable to keep your scheduled appointment, we require a 24 hour cancellation notice to avoid:
   - Fee: $30 missed office visit
   - Fee: $50 for procedures scheduled
   - Fee: $50 for Physical Therapy appointments

5. **Disability, FMLA, Workman's Compensation, other forms**: Administrative fees start at $10.

6. **Medical Record Copies**: fee according to number of pages *Digital x-rays*: $5 *X-ray films*: Not available

7. **Balances**: Statements are mailed the first week of the month. Prompt payment is requested. Accounts over 60 days past due from the insurance company may become the patient responsibility.

   - **Balances will accrue a $15 per month** statement fee after 60 days.
   - We offer *Care Credit* for monthly payments. (*no interest/low interest* between 6-24 months if you qualify).
   - Unpaid balances may be referred to our collection agency.

Please sign below to indicate you have read and understand our financial policy.

_____ _____

SIGNATURE of Patient or Legal Guardian Date

_____ _____

Patient's Name (please PRINT) *PRINT name of Legal Guardian*

NOTE: No revisions or changes to this form by you will be accepted

Acknowledgment of Receipt of the Notice of Privacy Practices

Patient Name:_____ DOB:_____

The above named patient acknowledges receipt of Centers for Foot and Ankle Surgery, Ltd dba/ **Foot & Ankle Centers** Notice of Privacy Practices. This notice provides detailed information about how we may use and disclose a patient's health information.

Authorization regarding Protected Health Information

_____ **(initial)** I authorize Foot & Ankle Centers, Ltd. contact me via text, voice, or email messages to the contact numbers provided on the registration form**.**

Name(s) of person(s) I authorize disclosure of my health / financial Information:

Name_____Relationship_____Phone_____ (_) Health (_) Financial

Name_____Relationship_____Phone_____ (_) Health (_) Financial

Authorization for treatment of minor by delegated person

I hereby authorize the following person(s) with my permission to seek medical treatment and sign for consent of treatment (*) of the above named minor child in my absence and his/her protected health information (**) may be shared.

Name_____ Relationship to patient_____ Ph#:_____

Name_____ Relationship to patient_____ Ph#:_____

It is **my** responsibility to **notify** Centers for Foot and Ankle Surgery, Ltd. dba/ Foot & Ankle Centers, of changes and to complete new form.

*Medical Treatment includes exam, procedures, injections, radiology.
**Protected Health Information includes but is not limited to test results, diagnosis, treatment and billing information. Highly confidential information will not be released unless the parent/legal guardian has also completed and Authorization for release of confidential information form. This information includes mental illness, or developmental disability, psychotherapy notes, HIV, or AIDS testing or treatment (including information regarding test ordering, performance or results, regardless if the results were positive or negative), sexually transmitted disease, substance abuse, abuse of an adult with a disability, sexual assault, child abuse or neglect, genetic testing.

I certify I am the parent and/or legal guardian, I consent to the examination and/or treatment of my child.

_____ _____
SIGNATURE of Patient or Legal Guardian Date

_____ _____
Patient's Name (please PRINT) *PRINT name of Legal Guardian*

In office use only: This form will expire on :_____(7 years from today)

☐ Entered in notes **(Example:** HIPAA MAY RELEASE (H/F) TO PATRICK (spouse) -630-401-3575- OK TO LEAVE VM MSG- EXPIRES 05/21/20

PMA Name _____ *Date* _____ *Patient Account number:* _____