Foot & Ankle Centers

New Patient Registration

PATIENT INFORMATION

First Name_______________________________ MI_________ Last Name__________________________________ ❍Male ❍ Female

Date of Birth_________/_________/___________ Age____________ Social Security Number _________-_________-________

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

Home Address__________________________________ PO Mailing Address [if applicable] ______________________________

City________________________________ State__________ Zip ____________ email (print)___________________________

Primary Contact number: ❍ Cell ❍ Home (Provide TWO contact numbers)

Cell ______________________ Home ______________________ Work _________________________ Other ___________

Preferred Language: ❍ English ❍ Spanish ❍ Other ________________

Patient Occupation______________________________________ Employer Name_______________________________________

Employer Address____

Emergency Contact Name__________________________________Ph#________________________Relationship___________

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

Address (if different from patient) _________________________ Cell______________________ Other Phone # ________________

PAYMENT AND INSURANCE INFORMATION

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

PRIMARY insurance ___________________ Full Name of Insured _______________________ Relationship to Patient_____________

Insured SSN________-_________-________ 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?

❍ Doctor Name____________________________________ Ph #__________________________

❍ Family Member ❍ Friend Name__________________________________ Address_________________________________

❍ Google ❍ Newspaper ❍ Saw our Sign ❍ Insurance Plan ❍ Our Website ❍ Radio ❍ Hospital ❍ Phone Book

❍ Facebook Yorkville Group ❍ Facebook ❍ Twitter ❍ Instagram ❍ Other _____________

CONSENT FOR PHOTOGRAPHY, VIDEOTAPING, OR OTHER IMAGING FOR MEDIA OR EDUCATION PURPOSES

I willingly give authorization and consent to Foot & Ankle Centers to use photographs, videotaped images, or other images of myself for the purpose of teaching (including other patients), advertisement on social or print media, and placement on our Foot and Ankle Centers, Med Foot Spa, or Physical Therapy websites.

______________________________ ___________ ____

Signature of patient/legal representative date If legal representative, relationship to patient

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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 birth mother's side; **F** on your birth 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			Nickel		
Anti-inflammatory meds			Novocain		
Aspirin			Peanuts		
Codeine			Penicillin		
Cortisone			Seafood		
Iodine			Other antibiotics		
Latex			Other pain medication 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. **Fees for Paperwork: Disability, FMLA, Workman's Compensation, other forms**: Fees ***start*** at $10.

6. **Medical Record Copies**: Fees will be assessed according to the law. *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/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

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Acknowledgment of Receipt of the Notice of Privacy Practices and Authorization regarding Protected Health Information

I give my consent for the Foot & Ankle Centers (FAC)/Centers for Foot & Ankle Surgery, Ltd. to use and disclose **P**rotected **H**ealth **I**nformation (PHI) about me (or the patient I am legally responsible for) to carry out **T**reatment, **P**ayment, and healthcare **O**perations (TPO).

With this consent, FAC may call my home or other alternative location and leave a message on voice mail, in person, or via text or via email provided about any items which assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others. With this consent, Foot & Ankle Centers may mail or email to my home or other alternative location any items which assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request FAC restrict how it uses or discloses my PHI to carry out TPO. Restrictions requests must be made in writing; however, FAC is not required to agree to my requested restrictions.

In the event FAC is unable to contact me, I give full permission to contact the individuals I have designated below for the purpose of disclosing information pertinent to my case. This would include, but not be limited to information regarding pathology reports, laboratory tests, scheduling, and business information. By my signature below, I agree to hold harmless and waive any liability against Foot and Ankle Centers/The Centers for Foot & Ankle Surgery, Ltd. for the disclosure of information to the individual below.

___________ **(initial)** I authorize to be contacted me via text, voice, or email as provided by me

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

Name___________________________________Relationship_______________________Phone_______________________ (_) Health (_) Financial

Name___________________________________Relationship_______________________Phone_______________________ (_) Health (_) Financial

I acknowledge I have been provided or directed access to the Notice of Privacy Practices, a copy of which is also available in our lobby AND at www.FootAndAnkleCenters.com which provides a complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.
We reserve the right to revise the Notice of Privacy Practices at any time.

I may revoke my consent in writing except to the extent FAC has already made disclosures in reliance upon my prior consent.
If I do not sign this consent, or later revoke it, Foot & Ankle Centers and Centers for Foot and Ankle Surgery, Ltd. may decline to provide treatment to me.

____ ____________________________________
SIGNATURE of Patient or Legal Guardian Date

____ ____________________________________
Patient's Name (please PRINT) PRINT name of Legal Guardian Date

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) -630-555-5555- OK TO LEAVE VM MSG- EXPIRES 01/01/21

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