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 _____

Emergency Contact Name_____Ph#_____Relationship_____

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

Address (if different from patient) _____ Cell_____ Other Ph # _____

Patient Occupation_____ Employer Name_____

Work Phone:_____

PAYMENT AND INSURANCE INFORMATION

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

PRIMARY _____ Full Name of Insured _____ Relationship to Patient_____

Insured Date of Birth (Required) _____ Insured SSN_____-_____-_____

SECONDARY _____ Full Name of Insured _____ Relationship to Patient_____

REFERRAL INFORMATION

How did you hear about our office?

❍ Doctor Name_____ Ph #_____

❍ Family Member/Friend ❍ Google ❍ Newspaper ❍ Signage ❍ Insurance Plan ❍ Website ❍ Radio ❍ Hospital/Urgent Care

❍ Facebook Yorkville Group ❍ Facebook ❍ Instagram ❍ Other _____

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

I voluntarily authorize and consent to the use of photographs and video images, with all identifiable information **removed**, for educational purposes, and practice only advertising.

_____ _____ _____

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

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 had any allergic reaction, rash, or side effects 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:_____

Address required: _____

Phone: _____

CONSENT for Treatment/Authorization for Payment

I confirm that the information provided is true and accurate to the best of my knowledge.

I consent to examination, treatment, and services provided by the doctors, their associates, or physical therapy staff.

I authorize *Centers for Foot & Ankle Surgery, Ltd. dba/ Foot & Ankle Centers* to release my medical information as needed to process insurance claims.

I authorize and request that my insurance company send payment directly to the practice.

Explanation of Benefits (EOBs) and statements will be under Centers for Foot & ankle Surgery, Ltd.

Patient Signature_____

Date _____

If signed by a parent or legal guardian, state relationship:

_____

Financial Policy Agreement

We participate in most insurance plans, including Medicare. It is the patient's responsibility to ensure we are a participating provider in your insurance network. **We are not participating providers for any Medicaid government plans**. If you are not insured by the plan we participate with, payment in full is expected at each visit. Knowing insurance benefits is patients' responsibility. Please contact your insurance company with any questions you may have regarding your coverage. No revisions or changes will be accepted

Patient's Responsibility:

- If correct insurance information is not provided, the balance will be transferred to you.
- HMO: the patient is responsible for requesting and providing us with a referral.
- **Co-pays, deductibles, self-pay, and deposits** are due at the time of service. Non-covered services are the patient's responsibility. Unpaid balances may be sent to collections.
- **Insurance balances** requiring patient action will be transferred to the patient after 60 days when patient fails to respond.

Cancellation/No show fees: We require a minimum of 24-hour notice to avoid:

- $50 missed office visit
- $50 for Physical Therapy appointments
- $150 for scheduled in-office procedures – *Requires 48-hour notice*
- $250 Scheduled Surgeries at a hospital or surgical center – *when made less than 7 business days before the scheduled appointment day.*

Additional Fees:

- **Paperwork:** Disability, FMLA, Workman's Compensation, other forms: Fees ***start*** at $10
- **Medical Record Copies**: Fees are assessed according to Illinois law.
- **Digital X-rays:** $5

By signing below, I acknowledge and understand that I am financially responsible for all charges incurred, including but not limited to co-pays, deductibles, non-covered services, and any remaining balance not paid by my insurance provider.

_____ _____

SIGNATURE of Patient or Legal Guardian *Date*

_____ _____

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

Note: If you choose not to sign, please be aware that we may be unable to proceed with non-emergency care, as we require written acknowledgment of financial responsibility for services rendered.

REV. 7/1/25 - dr

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

I acknowledge that I was provided access to the Notice of Privacy Practices electronically. A printed copy is available in the lobby and on our website at www.FootAndAnkleCenters.com. This notice describes how my protected health information (PHI) may be used and disclosed, and how I can access this information.

I understand I have the right to review the Notice of Privacy Practices before signing this acknowledgment. I am also aware that the practice may revise its Notice of Privacy Practices at any time, and that the revised notice will be made available upon request and posted prominently.

I give my consent for Centers for Foot & Ankle Surgery, Ltd.(dba/ Foot & Ankle Centers, Revitalize Physical Therapy) 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).

Consent for Communication and Disclosure

I authorize Centers for Foot & Ankle Surgery, Ltd. Centers for Foot & Ankle Surgery, Ltd.(dba/Foot & Ankle Centers, Revitalize Physical Therapy, MedFootSpa to contact me via phone, voicemail, text, email, or mail at my home or alternate location regarding matters related to treatment, payment, and healthcare operations (TPO), including appointment reminders, insurance, and clinical care.

If I cannot be reached, I consent to the disclosure of relevant information (e.g., lab results, pathology reports, scheduling, billing) to the individuals I have designated below. I release the practice from any liability related to such authorized disclosures

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

Name_____Relationship_____

Phone_____ ( ) Health ( ) Financial

Name_____Relationship_____

Phone_____ ( ) Health ( ) Financial

_____ _____

SIGNATURE of Patient or Legal Guardian Date

_____ _____

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

---

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

☐ Entered in notes **(Example:** HIPAA MAY RELEASE (H/F) TO First Name (spouse) -630-555-5555- OK TO LEAVE VM MSG- EXPIRES 01/01/31**)**

REV. 7/1/2025 - dr