

Welcome to our Practice

Foot & Ankle Centers

Centers for Foot and Ankle Surgery, LTD

Revised 12-6-11

PATIENT INFORMATION **Please print clearly**

Patient First Name _____ MI _____ Last Name _____

Male Female Marital Status: Single Married Widowed Divorced

Spouse/Partner Name _____ Spouse Date of Birth _____

Do you have children? Yes No Ages _____

Patient Home Street Address _____ Apt# _____

PO Mailing address [if applicable] _____

City _____ State _____ Zip _____

Patient Home Phone#[] _____ Cell Phone#[] _____

Patient email address **[please print clearly]** _____

May we text your cell phone with appointment reminders?: Yes No

BEST CONTACT INFORMATION Home Phone Cell phone Work Email

Patient Date of Birth _____ Age _____ Social Security Number _____

Patient Height _____' _____" Weight _____ Shoe Size _____

Patient Occupation _____ Employer Name _____

Employer Address _____ Phone[] _____

If patient is a minor – provide Name of parents or guardian _____

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

Phone #[] _____ Cell phone[] _____

Emergency Contact Name _____ Phone _____ Relationship _____

PAYMENT AND INSURANCE INFORMATION - Please present your insurance card and drivers license upon arrival

Check here if no health insurance

Full Name of Insured _____ Relationship to Patient _____

Insured SS# _____ Insured Date of Birth _____

Insured Employer _____

Employer Address _____

According to my insurance, I am responsible to pay a Co-Pay Amount \$ _____ Deductible Amount \$ _____

My insurance requires a referral from my PCP before I see a specialist. Yes No

REFERRAL INFORMATION *We appreciate your referrals! Who may we thank for referring you to our office?*

Name _____ Address _____

Is this person your: PCP Other Specialist Family Member Friend

Other Referral Sources [check all that apply and please specify names where indicated]:

Internet Search [name]↓	Phone Book [name]↓	Our Practice Website	Newspaper Ad [name]↓	Saw our sign	Insurance Plan or Website [name]↓	Other [explain]↓

Please turn over to continue

PODIATRIC HISTORY

Have you ever been to a podiatrist before? Yes No

What is your chief foot complaint for which you came to be treated?

When did it begin? _____

Did you receive treatment for this condition? Yes No

If so, what type? _____

Circle the degree of pain you are currently experiencing:
Minimal 1 2 3 4 5 6 7 8 9 10 Severe

Have you ever had any of the following foot conditions?
 Please check all that apply:

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

MEDICAL HISTORY

Have you ever been treated for any of the following conditions?
 Please ✓ all that apply to you;
 Put an **M** if on your mother's side;
 Put an **F** if on your father's side

- | | |
|---|--|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Muscle or Joint Pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Peripheral Arterial Disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Seizure Disorders |
| <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Varicose veins |

MEDICATIONS

Pharmacy Ph#: _____

Are you currently on Blood Thinners? Yes No

You can provide a printed list of your medications or list them below please use back of this page if needed:

Name of Medication	Strength/Mg	Take how often?

Do you currently use: Cigarettes or Tobacco? Yes No Quit

If yes, for how long? _____ How many pks/day? _____

If quit, when? _____ yrs _____ months

Alcohol use? Yes No If yes, quantity _____ daily _____ weekly

SURGERIES

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

Family Physician _____

Phone #: _____

Address _____

Date of Last Visit _____

ALLERGIES

Have you ever had any adverse side effects or allergies to:

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

**If other, please list _____

- ♦ I understand that the information provided on this form is true and correct to the best of my knowledge.
- ♦ I request that payments of authorized benefits be made on my behalf for any services furnished by Foot & Ankle Centers.
- ♦ I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent.
- ♦ I recognize my financial obligation of any coinsurance, co-pays or deductibles and non-covered services that may be required.
- ♦ I hereby give permission to Foot & Ankle Centers and any qualified staff to evaluate, diagnose and treat my foot and/or ankle condition as may be deemed necessary.

Patient or Authorized Signature ✓ _____

Date _____ If not patient, state relationship _____

Financial Policy

Thank you for choosing The Centers for Foot and Ankle Surgery, LTD /dba: Foot & Ankle Centers as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

- 1. Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- 2. Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.
- 2. Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.
- 3. Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. *You must pay for these services in full at the time of visit.*
- 4. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is *your* responsibility.
- 5. Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.
- 6. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
- 7. Non-payment.** Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 60 days past due, the balance becomes the patient responsibility if the insurance has not paid. Please be aware that if a balance remains unpaid, we may refer the account to a collection agency. If an account is referred a fee of 35% of the unpaid balance shall be added to the unpaid balance due to us (35% is the collection fee). By signing below, consumer acknowledges and declares that he or she knows and understands this provision. Please be aware that if the balance remains unpaid, we may discharge you and your immediate family members from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
- 8. Missed appointments.** Our policy is to charge \$30.00 for missed appointments not canceled within 24hrs or reasonable amount of time or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
- 9. Forms and Documents.** It is our policy to charge \$10.00 - \$25.00 for completion of all forms, such as disability applications, \$25 for copy of Medical records etc.
- 10. Fees and payments:** Our fees are representative of the usual and customary charges for our area. Payments can be made by cash, check, Visa/Mastercard, American Express and via our web page.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.
I have read and understand the payment policy and agree to abide by its guidelines:

✓ _____

Signature of patient or responsible party

Date

Privacy Statement

I hereby give my consent for Foot and Ankle Centers/Centers for Foot & Ankle Surgery, Ltd. (referred to as CFFAS in the remainder of this document) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Notice of Privacy Practices' provides a more complete description of such uses and disclosures.) I have the right to review the Notice of Privacy Practices prior to signing this consent. CFFAS reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Foot and Ankle Centers. Dina Rappette, Privacy Officer at 654 W Veterans Parkway, Suite D, Yorkville IL 60560-4567.

With this consent, CFFAS may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that 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**, Centers for Foot & Ankle Surgery, Ltd. may mail or email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that CFFAS restrict how it uses or discloses my PHI to carry out TPO. Restrictions requests must be made in writing. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

In the event that CFFAS is **unable** to contact me, I give full permission to contact the individuals that 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) It is ok to leave message regarding the above mentioned items on voicemail/answering machine.

NAME/Relation

Phone Number (home/cell/work)

By signing this form, I am consenting to Foot and Ankle Centers/ Centers for Foot and Ankle Surgery, Ltd. use and disclosure of my PHI to carry out TPO. **I may revoke my consent in writing** except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Foot and Ankle Centers/ 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

In office use only:

This form will expire on : _____ (7 years from today) Enter in ASPC notes.

PMA Name _____ Date _____ Patient Account number: _____