Foot & Ankle Centers

Centers for Foot and Ankle Surgery, LTD

Revised 02/23/2017/ds

Welcome to our Practice

PATIENT INFORMATION

Please print clearly and fill out completely – thank you.

First Name_____ MI_____ Last Name_____ Male❍ Female❍

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

Patient Home Street Address_____ Apt#_____

PO Mailing address [if applicable]_____

City_____ State_____ Zip _____

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

Patient's email address[please print clearly] _____*for appointment reminders & future access to the patient's portal page. The e-mail address is for **internal** use only & **not** shared.*

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_____

Preferred Language: ❍ English ❍ Spanish ❍ Other _____

Ethnicity: Not Hispanic or Latino ❍ Hispanic or Latino❍

Race: American Indian or Alaska Native ❍ Asian ❍ Black of African American ❍ White ❍ Other ❍ Unknown❍

Native Hawaiian or Other Pacific Islander ❍ Hispanic or Latino ❍

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 (primary care physician) before I see a specialist. Yes ❍ No ❍

REFERRAL INFORMATION

How did you hear about our office?

Name_____ Address_____

Is this person your: PCP (primary care physician) ❍ Other Specialist ❍ Family Member ❍ Friend ❍

Google ❍ Phone Book ❍ Newspaper Ad ❍ Saw our Sign ❍ Insurance Plan ❍ Website ❍ Yorkville Theatre ❍ Morris Theatre ❍

Facebook ❍ Twitter ❍ LinkedIn ❍ Hospital ❍ Other ❍ _____

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:

- ❒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 or tingling in foot or toes
- ❒ Plantar Fasciitis
- ❒ Postural Fatigue
- ❒ Pronation
- ❒ Shin Splints
- ❒ Sprains
- ❒ Sweating/Odor
- ❒ Tendonitis
- ❒ Tired feet
- ❒ Ulcers
- ❒ 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

- _____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

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 (PCP) _____

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 The Centers for Foot & Ankle Surgery, Ltd/ dba/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 The Centers for Foot & Ankle Surgery, Ltd/ dba/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√_____

Agreements and Authorization

Thank you for choosing The Centers for Foot and Ankle Surgery, LTD /dba: Foot & Ankle Centers as your foot and ankle care provider. We are committed to providing you with quality and affordable health care. Please read the following office policies and feel free to ask us any questions that you may have.

CONSENT TO HEALTHCARE SERVICES

By signing below I (or the person responsible for consenting on the patient's behalf) request and consent to all care, treatment and other services that may be provided by the doctors or their associates at the Foot & Ankle Centers. I understand that I have the right to refuse this care, as allowed under the law, and that no guarantees can or have been made to me in regards to my diagnosis and treatment at the Foot & Ankle Centers.

FINANCIAL POLICY

1. No-show Policy. We charge $30.00 for missed appointments and $50 for missed procedure appointments not canceled 24hrs prior to the appointment. These charges will be your responsibility and billed directly to you. Please keep all appointments.

2. Fees and copies. Our fees are usual and customary for our area and may change without notice. Form fees range from $10.00 - $25.00, such as disability applications. Medical records: $25 each copy. Digital x-rays: $5 each. X-ray films: $10 per sheet.

3. 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.

4. Proof of insurance. All patients must complete our patient information form and provide a copy of your driver's license and current valid insurance card, before seeing the doctor. 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 your insurance requires a referral you're your Primary Care Physician, it is *your* responsibility to obtain and provide us with that referral. If your insurance changes, please notify us before your next visit.

5. Claims submission. Your insurance policy and benefits is a contract between you and your insurance company. 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.

6. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This is part of your contract with your insurance company, and the Foot & Ankle Centers is not responsible for finding out if the services provided are covered by an insurance or other benefits. Payments can be made with cash, check, VISA, Mastercard, American Express and Care Credit.

7. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may not be covered by Medicare or your insurance company. *You must pay for these services in full at the time of visit*.

8. Non-payment. Invoices are sent out the first week of the month. 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. Care Credit is available as a way to pay larger balances with a monthly payment. Please log on to our web page to apply. An unpaid account may be referred to a collection agency. If the balance remains unpaid, we may discharge you and your immediate family members from this practice. If this occurs, 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.

Thank you for understanding the above and that **no revisions or changes to this form by you will be accepted** by the Centers for Foot and Ankle Surgery, Ltd. (dba: Foot & Ankle Centers).

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 give my consent for the Foot & 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 (or the patient I am legally responsible for) to carry out treatment, payment and healthcare operations (TPO). I acknowledge I have been offered a copy of CFFAS' Notice of Privacy Practices, a copy of which is also available in the CFFAS lobby and 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 any time. Questions about the Notice of Privacy Practices can be directed in writing to: **Foot & Ankle Centers, Privacy Officer Dina Rappette, 654 W Veterans Parkway, Suite D, Yorkville, Illinois 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 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**, Centers for Foot & Ankle Surgery, Ltd. 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 CFFAS restrict how it uses or discloses my PHI to carry out TPO. Restrictions requests must be made in writing; however CFFAS is not required to agree to my requested restrictions.

In the event CFFAS 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) It is ok to leave message regarding the above mentioned items on voicemail/answering machine.

NAME/Relation **Phone Number (home/cell/work)**

_____ _____

_____ _____

I may revoke my consent in writing except to the extent that CFFAS has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Foot & 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 eThomas notes.**

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