Foot & Ankle Centers

New Patient Registration Form

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 numbers)

Cell _____ 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 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?

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

❍ Doctor Name_____ Ph #_____

❍ Family Member ❍ Friend Name_____ Address_____

Please continue on the next 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 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. **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/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 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 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 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

I acknowledge I have been offered a copy of FAC Notice of Privacy Practices, a copy of which is also available on 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. FAC 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.

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

Authorization for treatment of minor by delegated person

Please fill this form out if anyone besides a parent or legal guardian will be accompanying minor to any future appointments.

I hereby authorize the following person(s) with my permission to seek medical treatment and sign for consent of treatment (*) of the 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 an 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*