NORTHERN ILLINOIS FOOT & ANKLE SPECIALISTS

PLEASE HAVE YOUR INSURANCE CARDS & ID AVAILABLE FOR THE RECEPTIONIST

Name_____ Phone ( )_____

Address_____ City _____ Zip_____

Age_____ Birthdate_____ Female/Male Marital Status: S M W D

SS#_____ Email Address_____

Preferred Method Of Contact Mobile Text Email

Primary Doctor_____ Phone ( )_____

City_____ Date Last Seen by PCP_____

How did you hear about Northern Illinois Foot & Ankle Specialists?

Billboard Office Sign Internet/Website Insurance Event/Other_____

Doctor Referral (name)_____Prior Patient Referral (name)_____

PLEASE CONTACT YOUR INSURANCE COMPANY PRIOR TO YOUR APPOINTMENT TO VERIFY YOUR BENEFITS

Insurance Company_____ Policyholder_____ DOB_____

Deductible_____ Co-Insurance_____

SS#_____ Co-Pay_____

Additional Insurance_____ Policyholder_____ DOB_____

Deductible_____ Co-Insurance_____

SS#_____ Co-Pay_____

IN CASE OF EMERGENCY, who will be notified? Phone ( )_____

Name_____ Relationship_____

By signing below, I hereby give permission to the physicians of Northern Illinois Foot & Ankle Specialists to evaluate, diagnose, and upon my approval, treat my foot and/or ankle condition(s)

Signature_____ Date_____

PATIENT HISTORY FORM

Patient Name _____ **Date** _____

Height _____ Weight _____ Shoe Size _____

Preferred Language English Spanish Other _____

Race Caucasian Hispanic African American Asian Native American Pacific Islander

Ethnicity Hispanic or Latino YES NO

Reason for today's visit:

_____

Location of areas involved:

_____

How long have you had this condition: _____

What aggravates your condition:

_____

What makes your condition improve:

_____

Pain Level 0-10 (10 being extreme) _____ Type of Pain: (sharp, achy, tingling, burning)

_____

Occupation: _____Percent of day you spend on your feet: _____

SMOKING/ DRINKING HISTORY (circle)

Never smoked Current Smoker - Packs per Day ___ Number of years _____ Former Smoker – Year quit____

Do you Drink alcohol? _____ Drinks per week _____

MEDICATIONS (list all current medications and dosages – including non-prescription counter medication) or **NONE**

_____

_____

_____

ALLERGIES – MEDICATION/ENVIRONMENTAL

No Known Allergies Penicillin Sulfa Tetracycline Codeine Adhesive Tape Latex Iodine/Betadine/Shellfish Radiographic Dyes Non-steroidal Anti-inflammatories (Advil, Motrin, Aleve)

_____

Other

_____

Type of Reaction

_____

ACTIVITY LEVEL/MAXIMUM WALKING DISTANCE (circle)

No Limitations Limitation of Daily Activities Limitation of Recreational Activities

Max Walking Distance: Greater than 8 Blocks 4-7 Blocks 1-3 Blocks Less than 1 Block

PAST MEDICAL HISTORY (circle all that apply) or **NONE**

Anemia Arthritis (Osteoarthritis) Arthritis (Rheumatoid) Asthma Blood Disorder Back Pain

Blood Clots Cancer COPD Gout Heart Disease Hepatitis (B or C) HIV+/AIDS

High Blood Pressure Kidney Disease Neurological Disorder Reflux Seizures Stroke

Thyroid Problem Stomach Ulcers Diabetes – Last Blood Sugar_____ A1C_____

Other _____

If female, is there a chance you are pregnant? YES NO

PAST SURGICAL HISTORY

_____

_____

FAMILY HISTORY of MEDICAL PROBLEMS

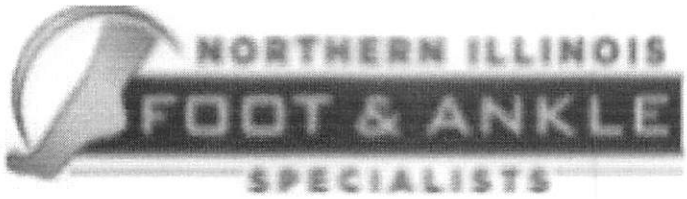
Alcoholism Asthma Blood Disorder Cancer Diabetes Heart Disease Hepatitis

High Blood Pressure Kidney Disease Neurological Disease Seizures Stroke Thyroid Problems

Foot Issues _____ Other _____

Preferred Pharmacy _____ City _____

Phone # _____



FINANCIAL POLICY

Northern Illinois Foot & Ankle Specialists is committed to providing you with the best possible care. If you have medical insurance, we will help you receive your maximum allowable benefits. It is your responsibility to provide us with any updated insurance information prior to treatment being rendered. Your insurance is a contract between you, your employer and the insurance company. We are NOT a party to that contract. We emphasize that, as medical care providers, our relationship is with you, not your insurance company. Please know your Insurance plan benefits and be aware that only your insurance company can tell you if the services provided are covered under your benefit plan. We do require, as your insurance benefits require, which includes payment of copays, co-insurance, and deductibles at the time of service. The federal government agency has determined that except for certain circumstances, the discounting or waiving of a patient's copay or deductible is unlawful.

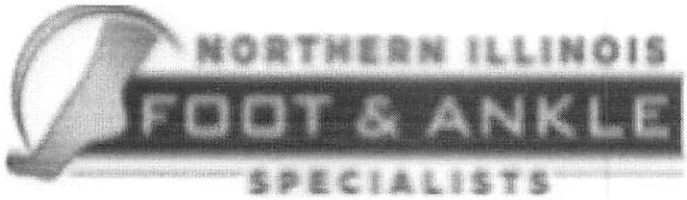
We need your assistance and understanding of our payment policy. Northern Illinois Foot & Ankle Specialists will file your insurance claims for reimbursement. However, you are financially responsible for all charges regardless of any applicable insurance or benefit payments. You agree to pay any additional costs if your account is turned over to a collection agency or attorney in an effort to collect any outstanding balance. This may include, but is not limited to, filing fees, court costs, collection agency fees and attorney fees.

Patient Appointments: We require a 24-hour notice for any cancellations. Failure to give 24-hour notice or missed appointments will incur a non-adjustable $25 fee. **Copays are due at the time of your appointment.** All returned checks will be charged a $25.00 NSF fee.

Financial Responsibilities: Bring your current insurance information to each visit. It is your responsibility to understand your insurance benefits, including co-pays, deductibles, and coinsurance.

Self Pay Patients: Payment for services rendered to uninsured patients is due at the time services are rendered. We accept cash, check or VISA/MC

Statements are mailed each month. Payment is due upon receipt unless other arrangements are made in advance. If payment is not received before the next statement date (25-30 days) the account is considered past due and may be assessed a monthly non-adjustable service charge of $10.00. Accounts that have not received any payments or acknowledgment for three (3) consecutive months will be referred to an outside collection agency. Anon-adjustable collection fee of 28% of the current outstanding balance will be added to the account. Refunds are processed only after all open claims on the account are processed. Deposits will be refunded after completion of insurance payment processing. Checks are mailed at the end of the month.



NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been made aware of Northern Illinois Foot & Ankle Specialists' privacy practices which is located on their website as well as in their office(s), available upon request. I authorize Northern Illinois Foot & Ankle Specialists to release and disclose such medical records, information, and documentation as may be necessary or appropriate to process insurance claims and to obtain payment on my behalf. I also authorize the release of information acquired during my examination or treatment, and all information pertaining to my history and care plan. I agree that a photocopy of my original authorization shall be considered equally authentic. I authorize the following persons and/or family members who have my permission in coordinating.

USE OF PHOTOS

I do hereby give Northern Illinois Foot & Ankle Specialists, their assigns, licensees and legal representatives, the irrevocable right to use my name, picture, photograph, portrait, visual likeness or voice in all forms and media in all manners, including photo, film, audio and video representations for public purposes. I also hereby give

Northern Illinois Foot & Ankle Specialists the irrevocable right to use pictures taken of my medical condition I am being treated for charting purposes.

I hereby waive any right to inspect or approve the finished product that may be created in connection therewith. I have read this release and am fully familiar with its contents.

CONSENT TO TREAT

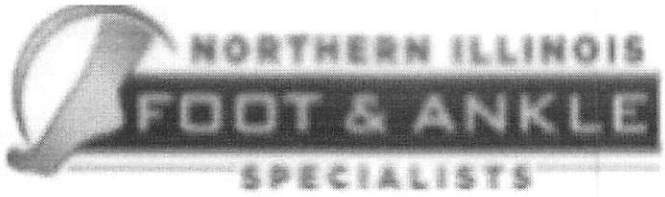
I hereby give permission to the physicians of Northern Illinois Foot & Ankle Specialists to evaluate, diagnose, and upon my approval, treat my foot and/or ankle condition(s)

ASSIGNMENT OF BENEFITS

I authorize Northern Illinois Foot & Ankle Specialists to release and disclose such medical records, information, and documentation as may be necessary or appropriate to process insurance claims and to obtain payment on my behalf.

MEDICAL RECORDS RELEASED

I also authorize the release of information acquired during my examination or treatment, and all information pertaining to my history and care plan to be released for medical care.



PATIENT NAME _____ **DOB** _____ **Phone #**_____

Social Security # _____ **Race/Ethnicity**_____ **Shoe Size** _____

Email:_____ **Portal Access: YES / NO**

Primary Care Dr_____**Date Last Seen**_____
Address_____**Phone**_____

- RELEASE OF INFORMATION, **I also authorize the release of information acquired during my examination or treatment, and all information pertaining to my history and care plan to be released for medical care.**

  Signature_____**Date**_____

- CONSENT TO TREAT, **By signing below, I hereby give permission to the physicians of Northern Illinois Foot & Ankle Specialists to evaluate, diagnose, and upon my approval, treat my foot and/or ankle condition(s)**

  Signature_____ **Date**_____

- FINANCIAL STATEMENT, I have read the above patient obligations and agree to follow this financial policy

  Signature_____ **Date**_____

- PATIENT PRIVACY POLICY, I have read any accept the Patient Privacy Policy

  Signature_____ **Date**_____

I also authorize the following persons/family members whom have my permission in coordinating my medical care:

Name_____DOB_____Relationship_____
Name _____DOB_____Relationship_____

- ASSIGNMENT OF BENEFIT, I authorize Northern Illinois Foot & Ankle Specialists to release and disclose such medical records, information, and documentation as may be necessary or appropriate to process insurance claims and to obtain payment on my behalf.

  Signature_____**Date**_____

- RIGHTS TO USE PICTURES, I also authorize the irrevocable right to use my name, picture, photograph, portrait, visual. **Signature**_____ **Date**_____