113 W. MAIN STREET
CARY, IL 60013

165. N LAKEWOOD, SUITE A
LAKE IN THE HILLS, IL 60156
847.639.5800

WELCOME TO OUR OFFICE

Name ____ Phone ( )____________________
Address ___________________________________ City _________________ Zip __________
Age ______ Birthdate ___________ Female /Male Social Security # ___________________
Email____
Preferred Contact _____Home Phone _____Cell Phone _____Email___________________

Father's Name______________________________Address ____________________________
Social Security #______________________________Cell Phone ( )___________________
Employer Name______________________________Work Phone ( )___________________

Mother's Name_____________________________Address ____________________________
Social Security #______________________________Cell Phone ( )___________________
Employer Name______________________________Work Phone ( )___________________

Family Doctor _________________________ Phone ( )______________ City ___________

How did you hear about Northern Illinois Foot & Ankle Specialists? (please circle or fill in)
Phonebook Office Sign Internet/Website Insurance Co Other ____________________
Doctor Referral (name) ________________Prior Patient Referral (name) __________________

PLEASE HAVE YOUR INSURANCE CARD AVAILABLE FOR THE RECEPTIONIST

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

Insurance Company_____________________ Policyholder______________ DOB_________
Deductible____________________ Co-Insurance _____________ Co-Pay___________

Additional Insurance_____________________ Policyholder______________ DOB _______
Deductible____________________ Co-Insurance _____________ Co-Pay___________

In case of emergency, who should 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 said minor's foot and/or ankle condition.

Signature ______________________________Relationship_____________ Date ___________

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NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been made aware of Northern Illinois Foot & Ankle Specialists Notice of Privacy Practices which is located on their website, as well as, available upon request in their office

_____ I place no restrictions

_____ Restrict all of my protected health information, except for the following individuals

Name _________________________ Relationship _________________ DOB ____________

Name _________________________ Relationship _________________ DOB ____________

____ Date ________________
Patient Name (please print)

____
Parent or Authorized Representative (if applicable)

____
Signature

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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**

____

____

____

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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

____

____

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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 # ____

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FINANCIAL AGREEMENT

We are committed to provide you with the best possible care. Payment for services rendered to uninsured patients is due at the time services are rendered. If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy. You must realize that 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.

Northern Illinois Foot & Ankle Specialists will file your insurance claims for reimbursement. You do understand, however, that 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 may incur a non-adjustable **$25 fee**.

Minors: Minors (under 18 years of age) must be accompanied by a parent or legal guardian in order to be treated. Any exception requires a signed "Authorization" to provide treatment. The parent(s) or guardian(s) accompanying a minor are responsible for payment.

Financial Responsibilities:
A: Bring your current insurance information to **each visit**. It is your responsibility to understand your insurance benefits, including co-pays, deductibles, and co-insurance.
B: **Self Pay Patients**: Payment is expected on the day that treatment is rendered. We accept cash, check or VISA/MC.
C: 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 days), then the account is considered past due and will be assessed a monthly non-adjustable service charge of $10.00.
D: Co-pays are due at the time of your appointment. Therefore, if it is necessary to mail a bill for any unpaid co-pay, the account will also be assessed a non-adjustable $10 service fee.
E: Accounts that have not received any payments or acknowledgement for three (3) consecutive months will be referred to a collection agency. A collection fee of 35% of the current outstanding balance will be added to the account.
F: All returned checks will be charged a **$25.00** administrative fee.

Durable Medical Equipment: Once durable medical equipment has left the office with a patient, it is considered used. Used equipment cannot be returned, as another patient cannot be expected to use it. Your insurance plan may or may not cover the expense of medical equipment provided by your doctor. If your insurance policy does not pay or applies the cost to your deductible, you will be responsible for payment in full.

I have read the above patient obligations and agree to follow this policy

_______________________________________ _________________________
Signature of Insured/Guardian Date