Clear

REGISTRATION **(FILLABLE PDF FORM)** **Advanced Foot and Ankle of WI, LLC**

PATIENT INFORMATION *(please print & complete all areas)*

Name _____ **SSN** ___-___-____
Last First MI

Address _____ City _____ State____ Zip____

Home # (___)_____ **Work #** (___) _____ **Cell #** (___) _____
*List only numbers we have consent to call

Email Address:_____

☐ Male ☐ Female **Date of Birth** ___/___/___ ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Age _____ **Ethnicity** ☐ African- American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other

Employer _____ **Occupation**_____

Employer Address_____

Spouse's Name_____ **Spouse's SSN**___-___-____

Spouses Employer_____ **Date of Birth**___/___/___

Emergency Contact_____ **Phone #** (___)_____ **Relationship**_____

INSURANCE

Person Responsible for Account / Insured_____
Last First MI

Primary Insurance_____ **Secondary Insurance**_____

Policy Holder Name_____ **Policy Holder Name**_____

Subscriber #_____ **Subscriber #**_____

Group #_____ **Group #**_____

** ***If patient is the <u>SPOUSE/CHILD OF THE INSURED</u>, the parent's information must be completed below:***

SSN ___-___-___ DOB___/___/___Home # (___)_____Relationship_____

Address _____ City_____State_____Zip_____

Employer _____Work #_____

ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage with aforementioned insurance carrier(s) and assign directly to my doctor all insurance benefits, if any, otherwise payable to me for services rendered. ***I understand that I am financially responsible for all charges whether or not paid by my insurance and accept responsibility for any balance remaining after payment of such benefits.*** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature of all my insurance submissions. I further authorize the physician to release any information required in the course of my treatment as authorized according to HIPAA Privacy Rules.

_____ _____ _____
Signature of Insured or Guardian Relationship Date

Clear

MEDICAL HISTORY FORM **Advanced Foot and Ankle of WI, LLC**

(THIS IS A FILLABLE PDF FORM)

Patient Name:_____

First MI Last

PRESENT ILLNESS OR INJURY

What is the reason (problem) for your visit to our office?_____

Who is your Primary Care Physician First/Last? _____ **Date last seen?**

Have you seen this or any other physician regarding this problem? ☐ NO ☐ YES

If YES, please state which doctor and when?_____

How were you referred to our practice? ☐ Doctor Referral – who?

☐ TV Commercial ☐ Health Fair ☐ Family ☐ Friend ☐ Listed in your insurance guide

☐ Internet ☐ Other, explain:

MEDICAL HISTORY

What is your current smoking status? ☐ Currently smoke ☐ Occasional ☐ Former Smoker ☐ Never smoked

Please indicate which Foot/Ankle problems you now have or have had in the past:

☐ Ankle Pain
☐ Athlete's Foot
☐ Bunions
☐ Corns and Calluses
☐ Cramps in Foot/Legs
☐ Flat Feet
☐ Heel Pain
☐ Ingrown Toenails
☐ Numbness in Feet, Legs, Toes
☐ Plantar Warts
☐ Swelling in Feet, Legs, Toes
☐ Tired Feet

Have you been diagnosed with any of the following: (you must indicate Yes or No)

Diabetes	Type 1 ☐	Type 2 ☐ No ☐
Hypertension	Yes ☐	No ☐
Peripheral Vascular Disease	Yes ☐	No ☐
Onychomycosis	Yes ☐	No ☐
Plantar Fasciitis	Yes ☐	No ☐

Have you been prescribed a foot orthotic? ☐ Yes ☐ NO If Yes, do you still use them? ☐ Yes ☐ No

ALLERGIES

Please tell us of any allergies you have and potential reactions (i.e. Nausea, hives) when encountered:

☐ Aspirin:_____ ☐ Novocain:_____

☐ Codeine:_____ ☐ Penicillin:_____

☐ Demerol:_____ ☐ Sulfa:_____

☐ Iodine:_____ ☐ OTHER:_____

MEDICATIONS

Please list any medications you are currently taking. If you require more space, please ask our receptionist to provide a piece of paper:_____

_____

SURGICAL / INJURY HISTORY

Please list the type of surgery and date:_____

_____

Please list injuries that required medical attention or hospitalization and the date:_____

_____

PATIENT HISTORY

Please mark Yes or No to indicate you have/have not had any of the following:

AIDS/HIV	Yes ☐	No ☐	Kidney Problems	Yes ☐	No ☐
Allergies to Anesthetics	Yes ☐	No ☐	Liver Disease	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐	Neuropathy	Yes ☐	No ☐
Artificial Heart Valves or Joints	Yes ☐	No ☐	Psychiatric Care	Yes ☐	No ☐
Back Problems	Yes ☐	No ☐	Radiation Treatment	Yes ☐	No ☐
Bleeding / Blood Disorders	Yes ☐	No ☐	Rash	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Respiratory Disease	Yes ☐	No ☐
Chemical Dependency	Yes ☐	No ☐	Rheumatic Fever	Yes ☐	No ☐
Chest Pain	Yes ☐	No ☐	Shortness of Breath	Yes ☐	No ☐
Circulatory Problems	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Swelling in Ankles, Feet	Yes ☐	No ☐
Foot or Leg Cramps	Yes ☐	No ☐	Swollen Neck Glands	Yes ☐	No ☐
Gout	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
Headaches	Yes ☐	No ☐	Ulcers	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐	Varicose Veins	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Venereal Disease	Yes ☐	No ☐

Is there a history in your family of any of the conditions shown above? ☐ YES ☐ NO

If Yes, please describe and include relationship:_____

_____

Are you now or have you been under another doctor's care for any reason in the last two years? ☐ YES ☐ NO

If Yes, please indicate for what reason: _____

Shoe size? _____

Height? _____ **What is your preferred Pharmacy?**

Weight? _____ **Name:** _____

Blood Pressure? _____ **Location:** _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistant or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Guarantor, or Responsible Party **Print name**

_____ _____

Date **Relationship to Patient**

Advanced Foot and Ankle of WI, LLC

Authorization to Release Information

Many of our patients allow specified individuals such as their spouse, parent or others to call and request the results of tests and procedures; or to contact us on their behalf to assist in explaining their statements. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have other specified individuals permitted to contact us on your behalf for the aforementioned purpose(s), you must specify to whom we may speak and you must sign this form.

I authorize Advanced Foot and Ankle of WI, LLC to verbally and/or physically (if requested) release my results and reports; and/or to discuss matters relating to my statements with the following individuals:

1._____ Phone #_____ Relationship to patient_____

2._____ Phone #_____ Relationship to patient_____

3._____ Phone #_____ Relationship to patient_____

Name of Patient: _____

Signature of Patient:_____ Date: _____

Authorization to Leave Message with Household Members/Answering Machine

From time to time it is necessary for representatives of Advanced Foot and Ankle of WI, LLC to leave a message for our patients. The purpose of these messages are to remind patients that they have an appointment, to notify the patient that medical staff would like to discuss lab or procedure results, or to ask a patient to call Advanced Foot and Ankle regarding an issue or concern. At no time will a representative of Advanced Foot and Ankle discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave a message with a member of your household, answering machine or personal cell phone.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Name of Patient: _____

Signature of Patient:_____ Date: _____

Advanced Foot and Ankle of WI, LLC - NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. We respect patient confidentiality and only release personal health information about you in accordance with state and federal law. This notice describes our policies related to the use of the records of your care generated by Advanced Foot and Ankle of WI.
Privacy Contact: If you have any questions about this policy or your rights contact the Privacy Officer at 262-763-9007.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care there are times when we will need to share your personal health information with others outside of Advanced Foot and Ankle of WI. This includes for-
Treatment- With your permission we may use or disclose personal health information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside of Advanced Foot and Ankle of WI that we are consulting with or referring you to.
Payment- Information will be used to obtain payment for any treatment and services provided. This includes contacting your health insurance company for prior approval of planned treatment or billing purposes.
Healthcare Operations- We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, and training staff.

INFORMATION DISCLOSED WITHOUT YOUR CONSENT

Emergencies- Sufficient information may be shared to address an immediate emergency you are facing.
Follow-up Appointments/Care- We will contact you to remind you of future appointments or regarding information about alternative treatments or other health-related benefits and services that may be of interest to you.
As Required By Law- This includes situations that involve a subpoena, court order, or a mandate to provide public health information such as communicable diseases or suspected abuse or neglect i.e. child, adult, or institutional abuse.
Coroners, Funeral Directors- We may disclose personal health information to a coroner, personal health examiner, or funeral director for the purposes of carrying out their duties.
Governmental Requirements- We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information with the Department of Health and Human Services to determine our compliance with federal laws related to healthcare.
Criminal Activity or Danger to Others- If a crime is committed on our premises or against our personnel, we may share information with law enforcement to aid in apprehension of the criminal. We also have the right to Involve law enforcement and to warn any potential victims when we believe an immediate danger may exist or we believe you present a danger to yourself.

PATIENT RIGHTS

You have the following rights under state and federal law:

Copy of Your Medical Records- You are entitled to inspect the personal health record we have generated about you. We may charge a reasonable fee for copying and/or mailing your record.
Release of Records- You may consent in writing to release your records to others for any purpose you choose. This includes your attorney, employer, or others who you wish to have knowledge of your care. You may revoke your consent at any time but only to the extent no action has been taken in reliance on your prior authorization.
Restriction on Record- You may ask us not to use or disclose part of your personal health information. This request must be in writing. We are not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to the Program Director who will consult with the staff involved in your care to determine if the request can be granted.
Contacting You- You may request that we send information to another address or by alternative means. We will honor such a request as long as it is reasonable, and we are assured it is correct. We have a right to verify the payment information you are providing us is correct. Due to agency
policy we are not able to provide information by email.
Amending Record- If you believe that something on your record is incorrect or incomplete you may request we amend it. To do this contact the Program Director and ask for the Request to Amend Health Information form. In certain cases, we may deny your request. If we deny your request for an amendment, you have the right to file a statement you disagree with us. All filing, statements, and response will be added to your medical record.
Accounting for Disclosures- You may request a listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. This also excludes information we were required by law to release. To receive information regarding disclosures made for a specific time-period no longer than six years prior, please submit your request in writing to our Privacy Officer. We will notify you of the cost involved in preparing this list.
Questions and Complaints- If you have any questions or complaints, you may contact our Privacy Officer in writing at our office for further information. You may also contact the U.S. Secretary of Health and Human Services if you believe Advanced Foot and Ankle has violated your privacy rights. We will not retaliate against you for filing a complaint.
Changes in Policy- Advanced Foot and Ankle reserves the right to change its privacy policy based on the needs of the practice and lo remain in compliance with state and federal law.

_____ _____

Signature of Patient Date

_____ _____

Signature of Minor patient's parent or legal guardian Relationship to patient

PATIENT FINANCIAL POLICY

Advanced Foot and Ankle of WI, LLC

Thank you for choosing Advanced Foot and Ankle of WI for your care. We will provide medical services to you provided that you understand and comply with the following financial policies of our practice. If you have any questions about the following, please ask to speak with one of our billing staff or office manager.

SUBMISSION OF INSURANCE CLAIMS

YOUR HEALTH INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR HEALTH INSURANCE PLAN. You are responsible for understanding and following your health plan's required procedures and policies. It is your responsibility to provide us with accurate and up-to-date insurance information, so that we can file an insurance claim on your behalf for services rendered. If we do not receive payment within 60 days from the date the claim is filed with your health plan, you are responsible for the unpaid balance and we may request immediate payment from you. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. It is your responsibility to contact your health plan regarding benefits or coverage issues.

REFERRALS AND PRIOR AUTHORIZATIONS

If your health plan requires you to have a referral authorization from your primary care physician in order to be seen by our practice, it is your responsibility to verify that a referral has been received by our office prior to your visit. FAILURE TO HAVE A VALID REFERRAL AUTHORIZATION MAY RESULT IN YOUR APPOINTMENT BEING RESCHEDULED UNTIL A VALID REFERRAL IS OBTAINED. If you request to be seen without a valid referral, you will be responsible for payment of services rendered and will need to complete additional paperwork that will allow us to bill you for services rendered. If your health plan requires surgery pre-authorization, please notify your provider of this provision. Our billing office will assist you in pre-authorization of your surgery. During the pre-authorization process, your health plan and your employer may be contacted to verify plan enrollment. Pre-Authorization does not guarantee payment of your surgery costs. Failure to have your surgery pre-authorized if required by your health plan may result in denial of medical payment for services rendered. If payment is denied, you may be responsible for payment of the balance in full. If you have any questions about your benefits or what services are covered under your health plan, it is your responsibility to contact your health plan prior to surgery.

CO-PAYMENTS AND NON-COVERED SERVICES

If your health plan required a co-payment, we are required to collect it at the time of your visit. We cannot waive co-payments, deductibles or co-insurance amounts, which are the patient's responsibility. Co-payments and non-covered services are collectable at the time of your visit. If you cannot make the required payment, your appointment may be rescheduled. If you do not have health insurance coverage or request a services that is not covered by your health plan (i.e., cosmetic in nature) we require that payment be made in full at the time that services are rendered. For your convenience, we accept cash, personal or cashier's check, VISA, MasterCard or Discover Card payments.

PATIENT RESPONSIBILITY FOR BILLED AMOUNTS

We will send you a statement of any remaining balance on your account after health plan payments are applied. Payment is due in full within 30 days from the date that appears on your billing statement. If you cannot make payment in full, you will need to contact our billing department to arrange a payment plan. If we do not receive payment from you within 60 days from the date of the first billing notice, we will attempt to contact you for a payment. If we receive no further response within the next 30 days, your account may be turned over to our collection agency. IF YOUR ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY, YOU WILL BE RESPONSIBLE FOR ALL COLLECTION COSTS AND LEGAL FEES INCURRED.

MINORS

A parent or legal guardian must accompany a minor and consent to treatment. Parents or legal guardians must comply with the terms of this financial policy. The parent or legal guardian that accompanies the minor will be held responsible for payment of services.

MISSING, INACCURATE OR INCOMPLETE BILLING INFORMATION

You are responsible for notifying our office of any health plan or billing information changes. Failure to notify us of changes may result in your being responsible for any remaining balance on your account. Our practice will not be responsible for any billing errors, lack of coverage or payment due as a result of missing, inaccurate or incomplete information that you provided us, including inaccurate information on secondary or third party payment coverage.

NO SHOW POLICY

Effective September 1, 2018, there will be a $75.00 No Show Fee billed to you upon a second No Show to our clinic without notification within 24 hours of your scheduled appointment.

I have read and understand the *Patient Financial Policy* for Advanced Foot and Ankle of WI, LLC and accept all the terms and conditions as stated above. I have received a copy of this policy.

_____ _____

Signature of Patient Date

_____ _____

Signature of Minor patient's parent or legal guardian Relationship to patient

Illinois State Medical Society

Are You at Risk for DVT?

FOR PATIENTS **Complete this risk assessment tool to find out.**

Be CLOT Aware — Know Your Caprini Score And Save Your Life

❑ Male
❑ Female

Name _____ Today's Date _____

Only your doctor can determine if you are at risk for Deep Vein Thrombosis (DVT), a blood clot that forms in one of the deep veins of your legs. A review of your personal history and current health may determine if you are at risk for developing this condition. Take a moment to complete this form for yourself (or complete it for a loved one). Then be sure to talk with your doctor about your risk for DVT and what you can do to help protect against it. Your doctor may want to keep a copy in your file for future reference.

Directions:

1. **Check all statements that apply to you.**
2. **Enter the number of points for each of your checked statements in the space at right.**
3. **Add up all points to reach your total DVT Risk Score.**

Then, share your completed form with your doctor.

Add 1 point for each of the following statements that apply now or within the past month:

- ❑ Age 41– 60 years _____
- ❑ Minor surgery (less than 45 minutes) is planned _____
- ❑ Past major surgery (more than 45 minutes) within the last month _____
- ❑ Visible varicose veins _____
- ❑ A history of Inflammatory Bowel Disease (IBD) (for example, Crohn's disease or ulcerative colitis) _____
- ❑ Swollen legs (current) _____
- ❑ Overweight or obese (Body Mass Index above 25) _____
- ❑ Heart attack _____
- ❑ Congestive heart failure _____
- ❑ Serious infection (for example, pneumonia) _____
- ❑ Lung disease (for example, emphysema or COPD) _____
- ❑ On bed rest or restricted mobility, including a removable leg brace for less than 72 hours _____
- ❑ Other risk factors (1 point each)*** _____

****Additional risk factors not tested in the validation studies but shown in the literature to be associated with thrombosis include BMI above 40, smoking, diabetes requiring insulin, chemotherapy, blood transfusions, and length of surgery over 2 hours.*

For women only: Add 1 point for each of the following statements that apply:

- ❑ Current use of birth control or Hormone Replacement Therapy (HRT) _____
- ❑ Pregnant or had a baby within the last month _____
- ❑ History of unexplained stillborn infant, recurrent spontaneous abortion (more than 3), premature birth with toxemia or growth restricted infant. _____

For more information call ISMS at 1-800-782-4767, ext. 1678

www.isms.org

Adapted with permission. Our thanks to ISMS member, J. A. Caprini, MD, associated with NorthShore University HealthSystem

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Add 2 points for each of the following statements that apply:

- ❑ Age 61–74 years _____
- ❑ Current or past malignancies (excluding skin cancer, but not melanoma) _____
- ❑ Planned major surgery lasting longer than 45 minutes (including laparoscopic and arthroscopic) _____
- ❑ Non-removable plaster cast or mold that has kept you from moving your leg within the last month _____
- ❑ Tube in blood vessel in neck or chest that delivers blood or medicine directly to heart within the last month (also called central venous access, PICC line, or port) _____
- ❑ Confined to a bed for 72 hours or more _____

Add 3 points for each of the following statements that apply:

- ❑ Age 75 or over _____
- ❑ History of blood clots, either Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) _____
- ❑ Family history of blood clots (thrombosis) _____
- ❑ Personal or family history of positive blood test indicating an increased risk of blood clotting _____

Add 5 points for each of the following statements that apply now or within the past month:

- ❑ Elective hip or knee joint replacement surgery _____
- ❑ Broken hip, pelvis or leg _____
- ❑ Serious trauma (for example, multiple broken bones due to a fall or car accident) _____
- ❑ Spinal cord injury resulting in paralysis _____
- ❑ Experienced a stroke _____

Add up all your points to get your total Caprini DVT Risk Score ☐

What does your Caprini DVT Risk Score mean?

- **Risk scores may indicate your odds of developing a DVT during major surgery or while being hospitalized for a serious illness.**
- **Airplane passengers who fly more than five hours may also be at risk for DVT.**
- **Studies have shown if you have 0-2 risk factors, your DVT risk is small. This risk increases with the presence of more risk factors.**
- **Please share this information with your doctor who can determine your DVT risk by evaluating all of these factors.**