ILLINOIS PODIATRY specialists

PATIENT REGISTRATION

Patient Name:_____ Gender: ☐Male ☐Female
Address:_____
City:_____State:_____ Zip Code:_____
Age:_____ Date of birth:_____
Marital Status: ☐Single ☐Married ☐Widowed
Preferred Phone:_____☐Home ☐Cell ☐Work
Alternate Phone:_____☐Home ☐Cell ☐Work
Email Address:_____

Employer:_____Occupation:_____
Primary Doctor:_____

Emergency Contact Person:_____
Relationship:_____
Phone Number:_____

DEMOGRAPHICS

Preferred Language: ☐English ☐Spanish ☐Other:_____

Race: ☐African American ☐American Indian ☐Asian ☐Caucasian
☐Hispanic/Latino ☐Other:_____

HOW DID YOU HEAR ABOUT US?

☐Family/Friend ☐Internet ☐Insurance Company ☐Phone Book ☐
Doctor's Referral Other:_____

Pharmacy:_____

INSURANCE INFORMATION

Insurance (If policyholder is someone other than patient)

Primary:_____	Secondary:_____
ID #:_____	ID #:_____
Name of policyholder:_____	Name of policyholder:_____
DOB:_____	DOB:_____
Address:_____	Address:_____
City:_____ State:_____	City:_____ State:_____
Zip code:_____	Zip code:_____
Phone Number:_____	Phone Number:_____
Relation to Patient:	Relation to Patient:
☐Spouse ☐Parent	☐Spouse ☐Parent
☐Other:_____	☐Other:_____

Reason For Visit

Main Problem:_____ **Which Foot:** ☐Right ☐Left ☐Both

How Long: _____Days _____Weeks _____Months _____Years

Check all that apply:

Pain Type: ☐Burning ☐Tingling ☐Sharp ☐Dull ☐Throbbing ☐Shooting ☐Stabbing ☐Numbness

Painful When: ☐Standing ☐Walking ☐Lying in bed ☐Worse in AM

Pain Level:(circle #) 1 2 3 4 5 6 7 8 9 10 (worst pain)

Height: _____	**Weight:** _____	**Shoe size:**_____

Review of Systems: circle all that you are **currently** experiencing

General:	Fever	Chills	Weight Loss or Weight Gain
Skin:	Rash	Itching	Suspicious Lesions
Respiratory:	Cough	Wheezing	Difficulty sleeping
Gastrointestinal:	Nausea	Vomiting	Diarrhea
Musculoskeletal:	Back pain	Joint pain/Swelling	Muscle cramps/aches
Circulation:	Leg cramps	Blood clots	Vascular disease
Neurological:	Numbness/Tingling		
Eyes:	Vision changes		
Cardiovascular:	Chest pain		

PATIENT HISTORY

MEDICAL HISTORY

☐ **None**	☐ Diabetes	☐ High cholesterol
☐ Anxiety	☐ Fibromyalgia	☐ Kidney problems
☐ Arthritis	☐ Gout	☐ Liver disease
☐ Asthma	☐ Heart Disease	☐ Neuropathy
☐ Cancer_____	☐ Hepatitis	☐ Stroke
☐ COPD	☐ High blood pressure	☐ Other_____
☐ Depression	☐ HIV	☐ Other_____

SOCIAL HISTORY

Do you smoke tobacco? ☐ Yes ☐ No If No: Did you ever smoke? ☐ yes ☐ No Quit:_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how often? _____

Recreational drug use? ☐ Yes ☐ No

Medical Merijuana use? ☐ Yes ☐ No

SURGICAL HISTORY

Procedure	Year

FAMILY HISTORY

	Father	Mother	Brother	Sister
Diabetes				
Arthritis				
Gout				
Other				

ALLERGIES

☐ **None** ☐ Penicillin ☐ Sulfa ☐ Iodine ☐ Aspirin ☐ Anesthetics ☐ Latex

☐ Codeine ☐ Vicodin ☐ Cortisone ☐ Seasonal ☐ Food:_____ ☐ Other_____

MEDICATIONS ***if you have a list, we will make a copy**

Medication	Dosage	For what?

ILLINOIS PODIATRY SPECIALISTS

FINANCIAL POLICY

PAYMENT FOR SERVICES: Payment for services is due once services are provided to you. We expect all charges we present to you at a visit will be paid at that visit, including copays and unpaid balances. You are responsible for copay amounts, coinsurance amounts, program deductibles, unpaid charges to account, and charges for services that are not covered by insurance or government programs. as determined by your insurance plan. Payments may be made by *cash, check, or credit card. P*ayment plans can be agreed upon with a credit card on file. This must be discussed with the office. There will be a $25.00 charge fo*r returned checks.*

INSURANCE: If your doctor is a participating provider with your insurance plan, we will submit the claim to your insurance company. To do this we must have accurate insurance information and a copy of your identification card or claim form. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. **Copays are due at the time of the visit.**

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, all charges for the services will be paid at the time of the visit.

BILLING COMMUNICATIONS: We will present charges to you by written statements via the mail.

ASSIGNMENT OF BENEFITS: I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible for all co-payments, deductible, unpaid balances, and non-covered services. I authorize the release of information required to process my claims.

COLLECTIONS: A collection fee equal to 40% of balance will be added to all delinquent accounts over 90 days past due that have to be sent to a collection agency.

DISABILITY AND FMLA PAPERWORK: There is a $20.00 fee regarding any disability and FMLA paperwork that needs to be completed.

X-RAY COPIES: There is a $5.00 charge for copies of x-rays.

LATE POLICY: If you are 10 minutes late, you will be asked to reschedule your appointment.

NO SHOW/NO CALL: If you do not show or call to cancel your appointment 24 hours prior, you will be charged $50. Insurance does not cover this fee. If you "no show/no call" for 3 appointments, you will be discharged from the practice.

INSURANCE TERMINOLOGY

This is for your knowledge and understanding. If you need further explanation, please contact your insurance company.

PREMIUM: the amount you pay every month towards your health insurance (NOT part of your deductible)

DEDUCTIBLE: the amount you must pay for your health care BEFORE your insurance benefits take effect

CO-PAY: the set amount you must pay for a health care service set by your insurance plan (usually paid per visit). A podiatrist is a specialist.

CO-INSURANCE: the percentage of health care cost you must pay once your insurer covers its share, it typically goes into effect once the deductible has been reached. For example, insurance will pay 80%a, but you are responsible for the other 20%

OUT OF POCKET: the maximum you must pay and then insurance will pay 100%. This includes your total deductible as well as your 20% co-insurance payments.

ILLINOIS PODIATRY SPECIALISTS

TREATMENT AGREEMENT

I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES HIPAA

I hereby authorize this practice to disclose both orally and in writing all facts pertaining the past, present, and future considerations, treatments, and services rendered with no exceptions. This includes diagnosis, prognosis, care and treatment, reports, testing, and changes. I understand that I may change this authorization in writing at any time**. Grab a copy on the front desk.**

Please include any legal guardians. You may release to the following people:

NAME	RELATIONSHIP	TELEPHONE

PATIENT COMMUNICATION CONSENT

Please check all methods of communication that you would prefer for your future appointments. Text message charges from your cell phone provider may apply.

✔	METHOD	NUMBER/EMAIL
	Office call	
	Automated call	
	Text	
	Email	

I acknowledge the Treatment Agreement, Notice of Privacy Practices, and Communication Consent and I have read (or had the opportunity to read) and understand them.

_____ _____

Patient Name(Please print) **Date**

_____

Patient/Guardian Signature

Credit Card on File Agreement – Effective August 1, 2021

Illinois Podiatry Specialists has implemented a new credit card policy. Recent changes in healthcare markets and payment processes have altered insurance coverages to shift more of the cost of care to our patients. The credit card on file policy is a convenient method to pay for the portion of services that are deemed patient's responsibility, such as copay, deductible and coinsurance. Co-pays are still due at time of visit. At check-in, the credit card information will be obtained and kept confidential and secure until the insurance(s) have paid their portion and notifies Illinois Podiatry Specialists of the balance due, if any. At that time, the billing department will issue one statement via mail in which the patient will have 30 days to pay the balance or make other payment arrangements. After 30 days, the debit/credit card on file will be automatically charged for any outstanding balance. In the case when a credit card has reached its limit maximum, the billing department will notify the patient via a mailed letter. The patient will have an additional 30 days to arrange payment before the bill is subject to additional collection activity. If you have any questions about the policy, please call us at 630-861-0156 or email your inquiries to contact@ilpodiatry.com.

I authorize Illinois Podiatry Specialists to keep my debit/credit card on file and to charge my debit/credit card for any outstanding balances that my health plan has identified as my financial responsibility. If the provided debit/credit card has changed, expired or denied for any reason, I agree to immediately give Illinois Podiatry Specialists a new, valid debit/credit card which I will allow to be charged over the phone. I agree that the new card will be used with the same authorization as the original card I presented.

_____ Date_____

Patient / Guarantor Signature