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:_____
Primary Doctor Phone #: _____

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 Authorization Agreement

Patient Name: _____

Date of Birth: _____

To help maintain the highest level of service and efficiency in our billing process, Illinois Podiatry Specialists require a valid credit card to be securely stored on file. This card will not be used at the time of service unless selected as your preferred payment method. The policy below outlines the circumstances under which your card may be charged.

Authorization Terms

1. Statement Notification

After services have been rendered and insurance has been processed, you will receive a statement detailing any remaining balance.

2. 90-Day Payment Window

You have 90 days from the date of the initial invoice to pay any outstanding balance using the payment method of your choice (e.g., credit/debit card, check, or cash).

3. Automatic Charges for Overdue Balances

If payment has not been received within 90 days of the invoice date, your credit card on file will be charged for the full outstanding balance without further notice.

4. Courtesy Reminders

We will make reasonable efforts to contact you with reminders before the 90-day period ends.

5. Secure Storage

Your credit card details are stored securely in compliance with industry standards, including PCI-DSS regulations.

6. Updating Information

You are responsible for ensuring that your credit card on file remains valid and up to date.

7. Billing Questions or Disputes

If you have any questions or concerns about a bill, please contact our billing department within the 90-day window to resolve the matter before any charges are processed.

8. Revocation of Authorization

This authorization remains in effect until revoked in writing by the patient. The patient may withdraw consent at any time by submitting written notice to Illinois Podiatry Specialists.

I have read, understand, and agree to the terms outlined above. I authorize Illinois Podiatry Specialists to charge my credit card on file for any balance unpaid after 90 days from the date of the invoice.

Patient Signature: _____ Date: _____

Printed Name: _____

Authorization for Use of AI Scribe Technology for Medical Documentation

Practice Name: Illinois Podiatry Specialists

Provider: Dr. Ramsha Tanwir

AI Scribe System Used: Freed AI

Purpose:

To enhance the quality, accuracy, and efficiency of your medical documentation, Illinois Podiatry Specialists uses Freed AI, an AI scribe technology, to assist in recording and generating clinical notes during your visit. This tool may use secure audio or text input to create draft documentation for your provider's review and approval.

What You Should Know:

- Freed AI is a secure, HIPAA-compliant system that helps document your visit but does not provide diagnosis or treatment.
- All documentation is reviewed and approved by Dr. Ramsha Tanwir before being added to your official medical record.
- Temporary data processing may occur via Freed AI, but no unauthorized access or third-party data sharing will take place.
- Use of the AI scribe is entirely optional and will not affect the quality of care you receive.

Authorization & Consent:

I hereby authorize Illinois Podiatry Specialists to utilize Freed AI scribe technology for the purpose of medical documentation during my visits.

I understand that:

- The AI scribe supports documentation only and is not involved in medical decision-making.
- I may request not to use AI-assisted documentation at any time.

- I may revoke this authorization in writing at any time.

Patient Name: _____

Date of Birth: _____

Signature: _____

Date: _____

If Signed by Personal Representative:

Name: _____

Relationship to Patient: _____