NEW PATIENT

FOOT & ANKLE ASSOCIATES, LTD.

4650 SOUTHWEST HIGHWAY, OAK LAWN, IL 60453

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: _____

☐ DR. ☐ MISS ☐ MR. ☐ MRS. ☐ MS.

PATIENT NAME: _____ _____ _____ AGE: _____
LAST FIRST MI

TO COMPLY WITH FEDERAL STANDARDS TO HELP ENSURE EQUAL ACCESS TO HEALTHCARE FOR ALL INDIVIDUALS, WE ARE REQUIRED TO ASK THE FOLLOWING:

1. DATE OF BIRTH: _____ 2. SEX: ☐ MALE ☐ FEMALE
3. PRIMARY/PREFERRED LANGUAGE: _____
4. ETHNICITY (CHECK ONE): ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO
5. RACE (SELECT AS (MANY AS APPLY): ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ WHITE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ HISPANIC ☐ OTHER

HOME ADDRESS: _____

CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: _____ ☐ YES ☐ NO

CELL/ALTERNATE PHONE #: _____ ☐ YES ☐ NO

WORK PHONE #: _____ ☐ YES ☐ NO

E-MAIL: _____ MAY WE SEND MESSAGES? ☐ YES ☐ NO
☐ PATIENT DOES NOT HAVE E-MAIL ADDRESS ☐ PATIENT DOES NOT WANT TO DISCLOSE E-MAIL ☐ OTHER _____

SOCIAL SECURITY #: _____

PRIMARY CARE DOCTOR: _____ **DATE LAST SEEN BY PRIMARY CARE DOCTOR:** _____

PRIMARY CARE DOCTOR'S OFFICE ADDRESS: _____ PHONE #: _____

PHARMACY: _____ **PHONE #:** _____ FAX #: _____

PHARMACY LOCATION: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED NAME OF SPOUSE/PARTNER: _____
☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? ☐ YES ☐ NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: _____

* **EMERGENCY CONTACT:** _____ RELATIONSHIP: _____ PHONE #: _____

* **WOULD YOU LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION WITH A FAMILY MEMBER OR OTHER PERSON?**

☐ **NO** ☐ **YES** **NAME(S)** _____

INDIVIDUAL RESPONSIBLE FOR PAYMENT: _____ DATE OF BIRTH: _____

(PLEASE NOTE: YOUR INSURANCE COMPANY IS NOT RESPONSIBLE FOR PAYMENT.)

RELATIONSHIP TO PATIENT: _____ PHONE #: _____ SOCIAL SECURITY #: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

* **HOW DID YOU HEAR ABOUT US? REFERRED BY:** ☐ PHYSICIAN (NAME) _____
☐ FOOTANDANKLEINSTITUTE.COM ☐ HOSPITAL WEB SITE: _____ ☐ OTHER WEB SITE: _____
☐ FAMILY MEMBER/FRIEND ☐ OTHER _____

PATIENT'S EMPLOYER:_____

ADDRESS:_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: _____

INSURED NAME: _____ DATE OF BIRTH _____ ID # _____ GROUP # _____

INSURED'S EMPLOYER: _____ ADDRESS: _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: _____

INSURED NAME: _____ DATE OF BIRTH _____ ID # _____ GROUP # _____

INSURED'S EMPLOYER: _____ ADDRESS: _____

YOUR MEDICAL HISTORY

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING OR ATTACH LIST (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE CAPSULE/LIQUID/ETC. HOW OFTEN DO YOU TAKE?

_____

_____

_____

_____

_____

_____

CURRENT OR PREVIOUS CONDITIONS:

ACID REFLUX	☐	FIBROMYALGIA	☐	NEUROPATHY	☐
ANEMIA	☐	GOUT	☐	OPEN SORES	☐
ARTHRITIS	☐	HEART ATTACK	☐	PNEUMONIA	☐
ASTHMA	☐	HEART DISEASE/FAILURE	☐	POLIO	☐
BACK TROUBLE	☐	HEPATITIS	☐	RHEUMATIC FEVER	☐
BLADDER INFECTIONS	☐	HIV+/AIDS	☐	SICKLE CELL DISEASE	☐
ABNORMAL BLEEDING	☐	HIGH BLOOD PRESSURE	☐	SKIN DISORDER	☐
BLOOD CLOTS	☐	KIDNEY DISEASE	☐	SLEEP APNEA	☐
BLOOD TRANSFUSION	☐	LIVER DISEASE	☐	STOMACH ULCERS	☐
BRONCHITIS/EMPHYSEMA	☐	LOW BLOOD PRESSURE	☐	STROKE	☐
CANCER	☐	MIGRAINE HEADACHES	☐	THYROID DISEASE	☐
DIABETES	☐	MITRAL VALVE PROLAPSE	☐	TUBERCULOSIS	☐

OTHER CONDITIONS: _____

WOMEN: ARE YOU PREGNANT ___YES ___NO IF SO, HOW MANY MONTHS? _____

ALLERGIES: ☐ MEDICATIONS_____ ☐ ANESTHESIA_____

☐ FOODS _____ ☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE

☐ OTHER _____ ☐ NONE

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

FAMILY HISTORY ☐ *PATIENT IS ADOPTED - FAMILY HISTORY IS UNKNOWN*

FAMILY MEMBER	**A**LIVE **D**ECEASED **U**NKNOWN	**AGE**	**DIABETES**	**HYPERTENSION (HIGH BLOOD PRESS.)**	**HEART DISEASE**	**CANCER**	**STROKE**	**CORONARY ARTERY DISEASE**	**RHEUMATOID ARTHRITIS**	**THYROID DISEASE**	**UNKNOWN**
FATHER											
MOTHER											
SIBLINGS											
DAUGHTER(S)											
SON(S)											
GRANDFATHER											
GRANDMOTHER											
UNCLE											
AUNT											
SPOUSE											

OTHER _____

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___ PACKS/DAY FOR _____ YEARS
☐ CURRENT USE - TYPE _____

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

OCCUPATION: _____ TYPE OF ACTIVITY: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND? _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY
TYPES OF EXERCISE: _____

CURRENT PROBLEM

- WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____
- HOW LONG AGO DID THIS PROBLEM FIRST START? _____ ☐ DAYS ☐ WEEKS ☐ MONTHS ☐ YEARS
- DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOPED OVER TIME
- HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING ☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____
- HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10?
  (NO PAIN) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 *(WORST PAIN POSSIBLE)*
- SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED
- WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES ☐ RESTING ☐ RUNNING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE ☐ OTHER _____
- WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____
- WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____
- HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____
- WAS THIS PROBLEM CAUSED BY AN INJURY OR ACCIDENT? ☐ NO ☐ YES (DESCRIBE) _____
  IF YES, WHERE DID THIS OCCUR? ☐ WORK ☐ HOME ☐ SCHOOL ☐ MOTOR VEHICLE ACCIDENT
- WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT

TOP OF FOOT

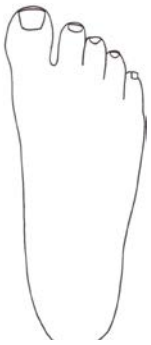
BOTTOM OF FOOT

INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT

BOTTOM OF FOOT



TOP OF FOOT

OUTSIDE OF FOOT

INSIDE OF FOOT

I HEREBY AUTHORIZE FOOT & ANKLE ASSOCIATES, LTD. TO TREAT ME IN ANY WAY THAT IS APPROPRIATE AND TO FURNISH INFORMATION TO MY INSURANCE CARRIER CONCERNING MY ILLNESS AND TREATMENT. TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS. I AGREE THAT FOOT & ANKLE ASSOCIATES, LTD. MAY REQUEST AND USE MY PRESCRIPTION MEDICATION HISTORY FROM OTHER HEALTHCARE PROVIDERS OR THIRD PARTY PHARMACY BENEFIT PAYORS FOR TREATMENT PURPOSES. I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME AND MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY MEDICAL BILLS NOT PAID BY MY INSURANCE CARRIER.

_____ _____

PRINTED NAME OF PATIENT, PARENT OR GUARDIAN | SIGNATURE OF PATIENT OR REPRESENTATIVE | DATE

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT | SIGNATURE OF DOCTOR | DATE

FOOT & ANKLE ASSOCIATES, LTD. PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- 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," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

Witness Signature: _____ Date: _____

Printed Name of Witness: _____

_____ Patient initials to indicate copy received.

SUMMARY OF NOTICE OF PRIVACY PRACTICES

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization: to family members or close friends who are involved in your health care; for certain limited research purposes; purposes of public health and safety; to government agencies for purposes of their audits, investigations, or other oversight activities; to government authorities to prevent child abuse or domestic violence; to the FDA to report product defects or incidents; to law enforcement authorities to protect public safety or to assist in apprehending criminal offenders; when required by a court order, search warrant, subpoena, or as otherwise required by law.

Patient Rights. As our patient, you have the following rights: to have access to and/or a copy of your health information; to receive an accounting of certain disclosures we have made of your health information; to request restrictions as to how your health information is used or disclosed; to request that we amend your health information; to receive notice of our privacy practices.

HIPAA Privacy Statement – Addendum (June 1, 2012)
This practice participates in a Health Information Exchange program where key clinical information about our patients' care is shared electronically, through a secure web portal, between this practice and other physicians/providers also providing care to our patients. Basic health information is shared with other treating physicians and providers. Sharing of basic health information in a Health Information Exchange is done so to have information available to better care for patients and the information is used for no other purposes. Your signature below is consent to participate in the Health Information Exchange program unless you have signed other documents to opt out of this. **LATER**, if you decide that you no longer wish to participate, any information in The Health Information Exchange cannot be removed, but it will not be viewable because the patient identifying information will be inactivated. If you wish to exclude your basic health information from being included in this program, please inform the practice manager. You will be asked to sign a form documenting your wishes to "Opt-out".

The following information is defined by the State of Illinois as specially protected health information and should ***only*** be shared with the patient's written permission in the Health Information Exchange, eEHX. This specially protected information includes information concerning alcoholism treatment, drug abuse treatment, mental health services, developmental disabilities services, genetic testing and treatment, testing and treatment for HIV/AIDS/Sexually Transmitted Disease, treatment for child abuse/neglect, and treatment of sexual assault or abuse. We have taken precautions to try and exclude this information from the Health Information Exchange, but there still is a small possibility that this information may be inadvertently sent to the HIE. **Therefore, if you have specially protected health information you should "Opt-out" of participating in the eEHX, or sign a consent that allows release of your specially protected health information.**

If you have a question, concern, or complaint regarding our privacy practices, please contact the Office Manager.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices.

_____ _____

Printed Name of Patient/Parent/Authorized Representative Date

_____

Signature of Patient/Parent/Authorized Representative