WELCOME

PATIENT INFORMATION

Date ______________________

SS/HIC/Patient ID # ______________________

Patient Name ______________________
Last Name

____
First Name Middle Initial

Address ______________________

City ______________________

State ____________ Zip ____________

E-mail ______________________

Sex ☐ M ☐ F Age ______ Birthdate ____________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______________________

Employer/School Address ______________________

____

Employer/School Phone (_____) ______________________

Spouse's Name ______________________

Birthdate ____________ SS# ____________

Spouse's Employer ______________________

Whom may we thank for referring you? ______________________

PHONE NUMBERS

Home Phone (______) ______________________

Cell Phone (______) ______________________

Best time and place to reach you ______________________

IN CASE OF EMERGENCY, CONTACT

Name ______________________

Relationship ______________________

Home Phone (______) ______________________

Work Phone (______) ______________________

INSURANCE

Who is responsible for this account? ______________________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________

Birthdate ____________ SS# ____________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with ______________________
Name of Insurance Company(ies)

and assign directly to Dr. ______________________ 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 insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to ______________________
Name of

______________________ for any services furnished to me by that provider.
Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

____
Signature of Beneficiary, Guardian or Personal Representative

____
Please print name of Beneficiary, Guardian or Personal Representative

______________________ ______________________
Date Relationship to Beneficiary

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

____

____

____

Have you ever been to a Podiatrist before?
☐ Yes ☐ No

If yes, please list.

Name ______________________

Last visit ______________________

Is there any personal or family history of diabetes?
☐ Yes ☐ No

Your occupation ______________________

Cigarette/Tobacco use ______________________

Years smoked ______________________

Athletic activities in which you participate (please list and indicate frequency)

____

____

____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Calluses	☐ Yes	☐ No
Cramps or Numbness in Feet or Legs	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Swelling in Ankles or Feet	☐ Yes	☐ No
Tired Feet		

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Rash	☐ Yes	☐ No
llergies to Anesthetics	☐ Yes	☐ No	Eye Problems	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Allergies to Medicine or Drugs	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Foot or Leg Cramps	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Artificial Heart Valves or Joints	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Swelling in Ankles, Feet	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis or Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tired Feet	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No	Neuropathy	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Ear Problems	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Surgeries you have had ______________________________

____

____

Hospitalization other than for the surgeries listed ______________________________

____

____

amily physician ______________________________ Last visit date ______________

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain ______________________________

____

____

____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins ______________________________

____

____

Pharmacy Name(s) ______________________________

Pharmacy Phone(s) (______) ______________________________

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

- ☐ Adhesive/Tape
- ☐ Anticoagulant Therapy
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Iodine
- ☐ Local Anesthetics
- ☐ Novocaine
- ☐ Penicillin
- ☐ Seafoods
- ☐ Sulfa

Other ______________________________

TREATMENT CONSENT

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

______________________________ ______________
Signature of Patient, Parent, Guardian or Personal Representative — Date

______________________________ ______________
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

FINANCIAL POLICY

Thank you for choosing University Foot Associates as your health care provider. We are committed to the successful treatment of your condition. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please call our billing department if you have any questions. They may be reached at 847-295-9300.

1. We are happy to bill your insurance company directly; however, we must have a copy of both sides of your current insurance card.
2. **If payment is not received from the insurance carrier or other responsible party within 90 days, we have the right to bill you directly. A rebill fee of $10.00 per month will be applied to all patient balances over 90 days old.**
3. If you do not have insurance or if you do not have your insurance, full payment is due at the time of service. We accept cash, check, Visa, MasterCard and Discover payments.
4. All patients must complete our "Patient Information Sheet" and other related forms.
5. A $100.00 fee will be applied if 48 hour notice is not given for a scheduled surgical procedure and a $25.00 fee will be applied for an office visit that is not cancelled 24 hours in advance.
6. Please notify us immediately of any changes in your insurance coverage.
7. 48 hours notice is required for copies of medical records. As allowed by Illinois Law, there will be a fee for these copies.
8. Should you cancel your appointment three times with less than 24 hours notice, you will be expected to hold your next appointment with a credit card. If you cancel this appointment, you will be charged.
9. A fee of $30.00 will be assessed on all returned checks.

SELF PAY

We accept payment at the time of service unless prior arrangements have been made.

MEDICARE

We accept Medicare assignment. As a Medicare patient you are responsible for the difference between the approved charge and the amount Medicare pays as well as any deductible amount. If you have supplemental insurance and provide the necessary information, we will be happy to submit the claim for you.

HMO/PPO

We are participating providers for most, but not all plans. It is your responsibility to verify that the physician with whom you have an appointment is in your plan. If you are HMO member you will not be billed as long as you are eligible for coverage and have the necessary referrals. **All co-payments are due at the time of service.** If your plan requires co-pay or a referral and you present without it, you will not be seen. If you arrange to have your primary care doctor fax a copy of the referral to us, it is your responsibility to verify that we received a legible copy.

WORKMAN'S COMPENSATION

If you are here as a result of a work related injury, we require information regarding both your health insurance as well as the workman's compensation coverage. You must present a letter from the Workman's Compensation carrier authorizing your treatment. The letter must include the claim number, address, adjuster's name and telephone number. We can submit a claim on your behalf and assign the benefits directly to you.

ACCIDENT

If you are here as a result of an accident claim, you must pay at the time of service. If you would like us to submit a claim on your behalf, you must provide the name, address and telephone number of your attorney. There is a nominal fee for copies of medical records.

USUAL AND CUSTOMARY FEES

We are committed to provide the best treatment possible for our patients and we charge what is considered usual and customary for our specialty in our locality. If we do not contract with your insurance company, you are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary fees.

I understand that I am entitled to ask prior to receiving services for the cost of the potential services. I understand that if the office agrees to bill my insurance as a courtesy, I must submit information as needed to ensure payment for services rendered to me. I understand that I am ultimately responsible for the payment of all services.

X

Patient Name (please print)	Patient/Responsible Party Signature	Today's Date

APPOINTMENT CANCELLATION POLICY

We are committed to providing all our patients with the finest clinical care and we appreciate the opportunity to serve you.

Our physicians reserve a significant amount of time for your office visit or procedure, and our staff invests a great deal of time in scheduling and registering you for your appointment. Please understand that untimely cancellations in our schedule create problems for our office and deprives the opportunity of another patient making use of that appointment. Furthermore, it jeopardizes our ability to ensure that you receive the medical care you need in a timely manner.

We realize that some patients may have an unavoidable need to change and appointment. However, we are requesting that when possible, you cancel your office visit or procedure in good time. The following provides our **Appointment Cancellation Policy:**

An **Office Visit** cancellation with less than 24 hours notice will result in an administrative fee of $25.00 charged to you and not to your insurance. Your next appointment will not be rescheduled until this fee is paid.
A **Surgical Procedure** cancellation with less than 48 hours notice will result in an administrative fee of $100.00 charged directly to you and not to your insurance. Your next appointment will not be rescheduled until this fee is paid.
A credit card will be necessary in order to schedule and hold your appointment time.
Your credit card information will be disposed of under strict HIPAA compliancy on the day after your appointment.
If more than two appointments are cancelled without notification, we will be unable to reschedule any office visits or procedures for you.

We hope that you understand the need for this policy. Once again, thank you for allowing us to participate in your medical care.

I, ______________________________, have read the above information and agree to the policy and terms regarding office visit/procedure cancellations.

X

Patient or Guardian Signature	Date

HIPPA AGREEMENT

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by University Foot Associates, and its employees or designees. I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs. (Initials:_____)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMTAION. I authorize use and disclosure of my personal health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. (Initials: _________)

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/ COLLECTION FEE. I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue I am responsible for associated rebill fees (as described in the Financial Policy) and if the overdue account is referred to a collection agency, I will be responsible for the cost of collection including reasonable attorneys' fees. (Initials: ____________)

PRIVACY POLICY. I acknowledge having received the Practice's, "Notice of Privacy Policies." My right including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, is explained in the Policy. I understand that I may revoke in writing any consent for release of my health care information, except to the extent the Practice has already made disclosures with my prior consent. (Initials: _________)

I understand that for convenience or necessity I would like my health information available to the following friends or family members:

Name	Relationship
Name	Relationship
Patient Name, (Please Print)	Date
Patient or Authorized Person Signature	Relationship
Date	Witness Signature

LAWRENCE A. SHORT, D.P.M.