General New Patient Form

PATIENT INFORMATION

please print clearly

First Name______________________________ MI_________ Last Name__________________________________ Male ❍ Female ❍

Date of Birth________________________ Age___________ Race _____________________________ Ethnicity: Hispanic / Non-Hispanic

Home Address____ Apt#_________________

City ____ State __________________ Zip __________________

Home Phone [_________] ____________________________________ Cell Phone [_________] ___________________________________

Appointments ~ Preferred Contact Method: Phone ❍ Email ❍ Text ❍

Billing ~ Preferred Contact Method: Phone ❍ Email ❍ Text ❍

Patient email address [please print clearly] ____

Preferred Pharmacy (please include cross streets and City): ____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name__________________________________Phone__________________________Relation______________

PAYMENT AND INSURANCE INFORMATION

- Please present your insurance card and driver's license upon arrival.

Check here if no health insurance or if self-pay ❍

Primary Insurance ____

Policy Holder ____ Date of Birth ____________________________

Secondary Insurance ____

Policy Holder ____ Date of Birth _____________________________

REFERRAL INFORMATION

How did you hear about our office?

○ Doctor _______________________ ○ Patient __________________________ ○ Friend/Family Member ___________________

Internet ○ ElmhurstFootDoc ○ Insurance Website ○ Google ○ Yelp ○ Elmhurst Memorial Website

Did you visit our website before scheduling your appointment? Yes ○ No ○

SIGNATURE ON FILE AND PERMISSION TO TREAT

- I understand that the information provided on this form is true and correct to the best of my knowledge.
- I request that payments of authorized benefits be made on my behalf for any services furnished by
- *Prairie Path Foot and Ankle Clinic.*
- I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent.
- I recognize my financial obligation of any coinsurance, co-pays or deductibles and non-covered services that may be required.
- I hereby give permission to *Prairie Path Foot and Ankle Clinic* and any qualified staff to evaluate, diagnose and treat my foot and/or ankle condition as may be deemed necessary.

√____ ____________________________________

Patient or Authorized Signature Date

If not patient, state relationship ____

PODIATRIC HISTORY

What is your *chief foot complaint* for which you came to be treated? ____

____

When did it begin? _____________________________

What goal(s) do you wish to obtain from treatment? ______

____

____

Previous Foot problems? _______________________

PATIENT CARE TEAM:

Primary Care Doctor: __________________City:_______

Date of Last Visit: __________________________

Referring Doctor: _____________________City: _______

Date of Last Visit: __________________________

MEDICAL HISTORY

Have you ever been treated for any of the following conditions?	
YOUR MEDICAL HISTORY	YOUR FAMILY MEDICAL HISTORY Please list any medical issues for your family:
_____Arthritis (type: _____)	Mother : ______________
_____Asthma	Father : ______________
_____Blood Clot	Grandmother : __________
_____Diabetes	Grandfather : __________
_____Heart Disease	Others : ______________
_____High Cholesterol	____________________
_____Cancer	____________________
If yes, what type? ________________	
_____Hypertension	
_____Thyroid Problem	
Other ______________	
________________	

SOCIAL HISTORY

Exercise ❍ None

Number of times per week? __________________

Type: ____________________________________

Level: _________

Do you currently use: Cigarettes or Tobacco? Yes ❍ No ❍

If yes, for how long? _________ How many pks/day? _______

Quit ❍ If quit, when? _________

Recreational Drug Use? Yes ❍ No ❍ Quit ❍

Alcohol use? Yes ❍ No ❍

If yes, quantity _________daily _______weekly

Occupation: ______________________________

Shoe Size: __________________

Height: _________________ **Weight:** ____________

Marital Status: ❍ Single ❍ Married

❍ Widowed ❍ Separated ❍ DP

SURGERIES

❍ None

Please list all surgeries	Approximate Date

MEDICATIONS

❍ None

Name of Medication	Take how often?

PLEASE LIST ALL ALLERGIES

❍ None

Allergen	Reaction

RUNNERS

❍ NA

Are you currently training for a race? Y N

If yes, what is the race name, distance and date?

____

How many miles a week do you run? ___________

Where do you run? (Treadmill, path, pavement)

____

Brand of running shoes ___________________

Do you wear orthotics? Yes ❍ No ❍

PEDIATRICS

❍ NA

Sports Played: ____________________________

Of hours per week: _________________________

Grade in school: _____________

Name of School: ____________________________

FinancialPolicy

Thank you for choosing *Prairie Path Foot and Ankle Clinic* as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

1. Insurance**.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please understand it is your full responsibility to know and understand the details of your insurance policy including, but not limited to, in versus out of network, co pays, deductibles, co-insurance and non-covered services. Coverage and benefits you are quoted are done in good faith from what we believe to be true, but is in no way a guarantee of payment or coverage. Please contact your insurance company with any questions you may have regarding your coverage. ***___Initial Here__***

> **a.)** Proof of insurance**.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become non refundable if the proper referral is not obtained by then.***___Initial Here___***
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> **b.)** Co-payments and deductibles**.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. ***___Initial Here___***
>
> **c.)** Coverage changes**.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. ***___Initial Here___***

2. Non-covered services**.** Please be aware that some - and perhaps all - of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit if we know it is non-covered. Sometimes we will not know until your insurance claim has gone through, for these you will be billed. ***Initial Here___***

3. Nonpayment. Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 60 days past due, you will receive a letter requesting immediate payment. A $10.00 rebilling fee will be charged for each additional invoice sent out after 30 days. Partial payments will not be accepted unless otherwise approved by our Billing Department. Please be aware that if a balance remains unpaid, we may refer your account collections with collection fees incurred by *Prairie Path Foot and Ankle Clinic* added. ***___Initial Here____***

4. Claims submission**.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

5. Missed appointments**.** Our policy is to charge $25.00 for missed appointments not canceled within 48 hours or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment. ***_____Initial Here_____***

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

√____ ________________

Signature of patient or responsible party Date

Privacy Statement

Prairie Path Foot and Ankle Clinic will use and disclose your health information for the following purposes: to treat you, to assist other health care provides in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. 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. If you have any questions, concerns or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices provided to you for the person(s) whom you may contact.

Additional Disclosure Authority:

In addition to the allowable disclosures described in the State of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Please circle your choice(s) below:

Any member of my immediate family	YES	NO
Spouse only	YES	NO
Other (Please specify)	YES	NO

Acknowledgement of Receipt of Notice of Privacy Practices:

(Signature represents that I have been offered a copy of the policy. These can also be found on our website.)

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understood the Notice.

√____ ______________________

Signature Date

____

Patient Name or Authorized Representative (Print)

Please bring this New Patient Packet
completed to your scheduled appointment.

Prairie Path Foot and Ankle Clinic

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