Prairie Path Foot & Ankle Clinic

General New Patient Form

Office Use Only
MA:

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 Ph (_ _ _) _ _ _ - _ _ _ _ Cell Ph (_ _ _) _ _ _ - _ _ _ _ Work Ph (_ _ _) _ _ _ - _ _ _ _
Appointments ~ Preferred Contact Method: ○ 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 _________________
Please list the name(s) of friends/family members so that we can enter them in our raffle drawing (if eligible.)
Internet: ○ ElmhurstFootDoc.com ○ Insurance Website ○ Google ○ Yelp ○ Elm. Mem. Website
Did you visit our website before scheduling your appointment? ○ Yes ○ No
Other ____

SIGNATURE ON FILE AND PERMISSION TO TREAT:

- 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 & Ankle Clinic (and M. McNeill DPM, Inc.)*
- 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 & 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 complaint for which you are seeking treatment? ______________________________

____

When did it start? _________ What is your goal(s) for treatment? _____________________________

Previous Foot Problems? ____

PATIENT CARE TEAM:

Primary Care Doctor: Last Name _______________________ First Name __________________________

Date of Last Visit: ________________ Ph: (_ _ _) _ _ _ - _ _ _ _

Full Physician Address: ____

MEDICAL HISTORY:

Check any of the following you have been treated for:

	You	Your Family	Family Member(s) affected
Arthritis (list type)	○ ______________	○ ____________	__________________________
Asthma	○	○	__________________________
Blood Clot	○	○	__________________________
Diabetes	○	○	__________________________
Heart Disease	○	○	__________________________
High Cholesterol	○	○	__________________________
Cancer (list type)	○ ______________	○ ____________	__________________________
Hypertension	○	○	__________________________
Thyroid Problems	○	○	__________________________

Please list anything else you feel we should be aware of in your or your family history: ____________

____

SOCIAL HISTORY:

Exercise: ○ No ○ Yes - Times/wk: ________ Type: _________________ Level: _______

Cigarettes/Tobacco Use? ○ No ○ Yes – How long? ________ pks/day? _____ ○ Quit - When: ________

Recreational Drug Use? ○ No ○ Yes ○ Quit

Alcohol use? ○ No ○ Yes – Quantity ________ daily ________ weekly

Occupation: ______________________________ Shoe size: ___________ Ht: ___________ Wt: ___________

Marital Status: ○ Single ○ Married ○ Widowed ○ Separated ○ Domestic Partner

SURGERIES:

○ None

Surgery: ______________________ Date: __________ Surgery: ______________________ Date: __________

Surgery: ______________________ Date: __________ Surgery: ______________________ Date: __________

Surgery: ______________________ Date: __________ Surgery: ______________________ Date: __________

MEDICATIONS:

○ None

Medication: _______________________________ Dosage: ___________ Taken How Often: ______________

Medication: _______________________________ Dosage: ___________ Taken How Often: ______________

Medication: _______________________________ Dosage: ___________ Taken How Often: ______________

Medication: _______________________________ Dosage: ___________ Taken How Often: ______________

ALLERGIES:

○ None

Allergen: ___________________ Reaction: _________ Allergen: ___________________ Reaction: _________

Allergen: ___________________ Reaction: _________ Allergen: ___________________ Reaction: _________

ATHLETES:

○ N/A ○ Yes -Sport(s) ____

Time/Week _______________________ Duration/Distance ____

Any upcoming events/races/tournaments/recitals? ○ No ○ Yes - Date ____________________________

PEDIATRICS:

○ N/A Sport(s): ____ Hrs/wk: ______________

School: ____Grade: ________________

FINANCIAL POLICY

Thank you for choosing *Prairie Path Foot & 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 much complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card 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
    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. Co-payments are required before your office 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 non-covered 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, and 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 you 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 to collections and collection fees incurred will be added to your balance.
____
Initial Here
4. **Claims submission -** We will submit your claims and assist you in any way we reasonable 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 appointment –** Our policy is to charge $25.00 for missed appointments not cancelled 48 ahead of time 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 & Ankle Clinic will use and disclose your health information for the following purposes: to treat you, to assist other health care providers 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, concern 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:

○ Yes ○ No Any member of my immediate family
○ Yes ○ No Spouse only
○ Yes ○ No Other (Please Specify) : ______________________________
____
____

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 & Ankle Clinic
www.ElmhurstFootDoc.com

136 W Vallette St. ~ #2 ~ Elmhurst ~ IL ~ 60126

630.834.3668