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*

DON'T FORGET THE BACK!

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 (attached below) 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

NOTICE OF PRIVACY PRACTICES

Your Information ~ Your Rights ~ Our Responsibilities

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully

Your Rights - When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record –

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visitingwww.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tellus what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures - How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities –

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date of Notice: February 13, 2018

For more information contact our privacy officer:
Kassandra Delmedico: 136 W. Vallette St., #2, Elmhurst, IL 60126
Phone: 630.834.3668 Email: kassandra@elmhurstfootdoc.com