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 _____

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)

FINANCIAL POLICY – *Please Read Carefully!*

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 and to being transparent with our billing process. Please read the following policy. Feel free to ask us any questions that you may have. Please add your initials to each statement indicating that you understand. When you have accepted the policy, please sign in the space provided. A copy will be provided to you upon request.

_____ It is my responsibility to **provide up-to-date insurance** information prior to my appointment and each time my insurance changes.

_____ PPFAC must maintain a **copy of my Insurance and ID Cards** as protection for me against fraud.

_____ If I do not have an insurance that PPFAC participates in or I fail to provide up-to-date insurance information for a plan PPFAC does participate in, I will need to pay in full for all charges.

_____ It is my **full responsibility to know and understand the details of my insurance policy** including, but not limited to, in vs. out of network, co-pays, deductibles, co-insurance and non-covered services.

_____ **Coverage & benefits quotes I am given are provided in good faith** from what PPFAC has been told by my insurance, but are in **no way a guarantee of payment or coverage**. It is my responsibility to contact my insurance company with questions I have re: my coverage.

_____ If required, it is **my responsibility to obtain a proper referral**. Failure to do so will result in my paying in full for all charges. This payment will be held for 48 hours and will become non-refundable if proper referrals are not presented by that time.

_____ **All anticipated patient responsible charges must be paid at the time of service**, this includes co-pays, co-insurance, deductibles and non-covered services. If it is not known that a service is non-covered until after the appointment, I will be billed for that service.

_____ Services associated with my visit will be promptly sent to insurance for claim processing. After my insurance has processed the claim(s), I will receive a statement listing charges that are my responsibility. **I agree to pay in full within 30 days of statement date**.

_____ If there is an outstanding balance on my or my family's account(s), I will need to **pay in full at the time of check-in**.

_____ PPFAC does NOT accept cash, and that all major credit cards and checks are accepted.

_____ Unpaid balances **past 30 days are subject to a $10 repeat statement fee**.

_____ Unpaid balances **past 60 days may be sent to a collection agency** and fees associated with that agency will be added to my balance.

_____ PPFAC does not offer payment plans. Note: Care Credit is available for application through our office.

_____ PPFAC will submit my claims and assist me in any way reasonable to help get my claims paid. My insurance company may need me to supply certain information directly. **It is my responsibility to comply with their request**.

_____ **Cancellations must be made 2 business days in advance**. Failure to do so will result in a $25 fee.

_____ Appointments not cancelled, and not kept are deemed **'No-shows' and will incur a $50 fee**.

_____ After 3 No-shows and/or late cancellations, I will be required to leave a non-refundable deposit for future appts. The deposit will be applied to any balance due at kept appointments.

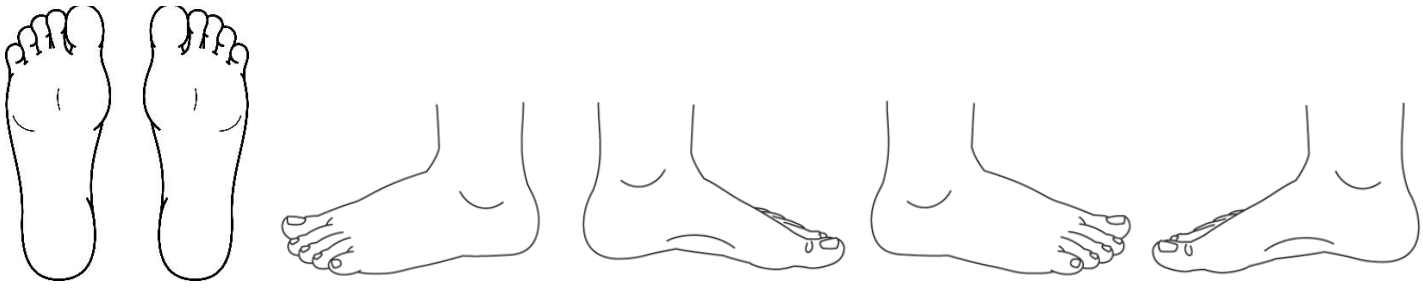
I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

FOOT & MEDICAL HISTORY

Please draw an X where you have pain and a ★ on the one spot that is most painful.



Left Right Left Outside Left Inside Right Outside Right Inside

How long have you had symptoms? _____

What treatments have you tried? _____

Have you seen another Doctor for this? (circle one) Yes No

If you have pain, please fill out below:

Did you have an injury? (circle one) Yes No Date: _____ Where did it occur? Home Work Other: _____

Rate your pain on scale of 1-10 with 10 being the High Pain: At it's worst: _____ On Average: _____

Describe the pain (dull, achy, sharp, shooting, burning, etc): _____

Is the pain getting: (circle one) Worse Better Staying the same

What makes it worse (standing, exercise, rest, pressure, shoe gear, activity) _____

What makes it better (rest, ice, supportive shoes): _____

Pharmacy Name/City/Ph: _____ I give consent to request Rx History: Yes No

Primary Care Physician Name/City/Ph: _____

Do you have a history of adverse reactions to any of the following (circle Yes or No for each, if yes, please list specifics):

Antibiotics/Sulfa Drugs	Yes	No	_____
Anti-inflammatories	Yes	No	_____
Anesthetic Medications	Yes	No	_____
Pain Medications	Yes	No	_____
Betadine/Topical Meds/Latex	Yes	No	_____
Oral/injected Steroids	Yes	No	_____
Environmental/food allergies?	Yes	No	_____

Do you have any of the following medical issues (circle all appropriate): I have no Medical Issues

Diabetes	Skin/other Cancer	History of Stress Fractures	Kidney Disease/Dialysis	Arthritis: Type_____
Blood Clot	Open Sore/Ulcer	Heart Disease/Heart Attack	Vein/Circulation Issues	Osteoporosis
Gout	High Blood Pressure	Other: _____		

Have you ever had any surgical procedures done? Yes No _____

Have you/your family ever had a reaction to anesthesia? Yes No _____

This Section for Over 18 Only:

Emergency Contact Name: _____ Phone: _____

Occupation: _____ Shoe Size: _____ Height: _____ Weight: _____

Do you exercise? Yes No If yes, Times/week: _____ Type: _____ Level: _____

Cigarette/Tobacco Use? Yes No If yes, how long: _____ Pks/day: _____ Quit when: _____

Recreational Drug Use? Yes No Quit Alcohol Use? Yes No Quantity _____ daily _____weekly

Marital Status (circle appropriate): Single Married Widowed Separated Domestic Partner