ILLINOIS
Foot & Ankle
CENTER
Kelly N. May, DPM, FACFAS

PATIENT REGISTRATION

Patient Name: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Age: _____ Date of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed

Preferred Phone: _____ ☐ Home ☐ Cell ☐ Work

Alternate Phone: _____ ☐ Home ☐ Cell ☐ Work

Email Address: _____

Appointment Reminders: ☐ Email ☐ Text ☐ Office Call ☐ Voice reminder

Employer: _____ Occupation: _____

Primary Doctor: _____

Emergency Contact Person: _____
Relationship: _____
Phone Number: _____

DEMOGRAPHICS

Preferred Language: ☐ English ☐ Spanish ☐ Polish ☐ Other: _____

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Other: _____

HOW DID YOU HEAR ABOUT US?

☐ Family/Friend: _____ ☐ Google/Internet ☐ Insurance Company

☐ Doctor Referral ☐ Drive-by ☐ Other: _____

PHARMACY

Name: _____ Intersection/City: _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

PATIENT HISTORY

MEDICAL HISTORY

☐ **NONE**
☐ Anxiety
☐ Arthritis: _____
☐ Asthma
☐ Cancer: _____
☐ Depression
☐ Diabetes Type ____
☐ Gout
☐ Heart disease
☐ Hepatitis
☐ High blood pressure
☐ HIV
☐ High cholesterol
☐ Multiple Sclerosis
☐ Neuropathy
☐ Osteoporosis/Osteopenia
☐ Parkinson's
☐ Thyroid
☐ Restless Leg Syndrome
☐ Stroke
☐ Other _____

SOCIAL HISTORY

Do you smoke tobacco? ____Yes ____No If No: Did you ever smoke? ____Yes ____No
Do you drink alcohol? ____Yes ____No
Recreational drug use? ____Yes ____No
Medicinal Marijuana ____Yes ____No

SURGICAL HISTORY

Procedure	Year

FAMILY HISTORY

	Father	Mother	Brother	Sister
Diabetes				
Heart Disease				
High Blood Pressure				
Cancer (what type)				
Other				

ALLERGIES

☐ **NONE** ☐ Penicillin ☐ Sulfa ☐ Iodine ☐ Aspirin ☐ Anesthetics ☐ Latex
☐ Codeine ☐ Vicodin ☐ Cortisone ☐ Seasonal ☐ Shellfish ☐ Other _____

MEDICATIONS *If you have a list, we will make a copy

Medication	Dosage	How Often?	For What?

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TREATMENT AGREEMENT

I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES HIPAA

I hereby authorize this practice to disclose both orally and in writing all facts pertaining the the past, present, and future considerations, treatments, and services rendered with no exceptions. This includes diagnosis, prognosis, care and treatment, reports, testing, and changes. I understand that I may change this authorization in writing at any time. **Grab a free copy on the desk**

Please include any legal guardians. You may release to the following people:

Name	Relationship	Telephone

I acknowledge the Notice of Privacy Practices (HIPAA) and I have read (or had the opportunity to read) and understand the Notice. I understand and agree to the Treatment Agreement. I also received a copy of the Financial Agreement. I agree to the Communication agreements.

_____ _____

Patient Name (please print) Date

_____

Patient/Guardian Signature

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CREDIT CARD AUTHORIZATION FORM

Illinois Foot & Ankle Center S.C. requires all patients to keep a credit card on file to cover any patient responsibility for services rendered.

Note: When your credit card information is entered it is encrypted and cannot be viewed or accessed by our organization. Our system is independently certified as PCI compliant, ensuring that strict security standards are in place.

AUTHORIZATION

I authorize Illinois Foot & Ankle Center S.C. to charge the patient responsibility balance on my account to the following credit card:

Circle One: Visa MasterCard Discover AMEX

Last Four Digits of Credit Card Number: _____

Expiration Date: (mm/yy) _____/_____

I understand that once the insurance has paid their portion, I will receive ONE statement from Illinois Foot & Ankle Center indicating my responsibility.

I agree that Illinois Foot & Ankle Center may charge my credit card the balance due if it is not paid in 30 days of the statement date. I also understand that Illinois Foot & Ankle center my charge my credit card any open balance due as well if they determine that a prior balance exists.

Printed Name: _____ **Date:** _____

Signature: _____

Patient Name (if different than cardholder): _____

Patient Date of Birth: _____/_____/_____

ILLINOIS FOOT AND ANKLE CENTER, SC
FINANCIAL POLICY

PAYMENT FOR SERVICES: Payment for services are due once services are provided to you. We expect all charges we present to you at a visit will be paid at that visit, including copays and unpaid balances. You are responsible for copay amounts, coinsurance amounts, program deductibles, unpaid charges to account, and charges for services that are not covered by insurance or government programs, as determined by your insurance plan. Payments may be made by *cash, check, or credit card.* Payment plans can be agreed upon with a credit card on file. This must be discussed with the office. There will be a $25.00 charge for *returned checks.*

INSURANCE: If your doctor is a participating provider with your insurance plan, we will submit the claim to your insurance company. To do this we must have accurate insurance information and a copy of your identification card or claim form. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. **Copays are due at the time of the visit.**

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, all charges for the services will be paid at the time of the visit.

BILLING COMMUNICATIONS: We will present charges to you by written statements via the mail.

ASSIGNEMENT OF BENEFITS: I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible for all co-payments, deductible, unpaid balances, and non-covered services. I authorize the release of information required to process my claims.

COLLECTIONS: A collection fee equal to 40% of balance will be added to all delinquent accounts over 90 days past due that have to be sent to a collection agency.

DISABILITY AND FMLA PAPERWORK: There is a $20.00 fee regarding any disability and FMLA paperwork that needs to be completed.

X-RAY COPIES: There is a $5.00 charge for copies of x-rays.

LATE POLICY: If you are 10 minutes late, you will be asked to reschedule your appointment.

NO SHOW/NO CALL: If you do not show or call to cancel your appointment 24 hours prior, you will be charged $40. Insurance does not cover this fee. If you "no show/no call" for 3 appointments, you will be discharged from the practice.

INSURANCE TERMINOLOGY

- This is for your knowledge and understanding. If you need further explanation, please contact your insurance company.

PREMIUM: the amount you pay every month towards your health insurance (NOT part of your deductible)
DEDUCTIBLE: the amount you must pay for your health care BEFORE your insurance benefits take effect
CO-PAY: the set amount you must pay for a health care service set by your insurance plan (usually paid per visit). A podiatrist is a specialist.
CO-INSURANCE: the percentage of health care cost you must pay once your insurer covers its share, it typically goes into effect once the deductible has been reached. For example, insurance will pay 80%, but you are responsible for the other 20%
OUT OF POCKET: the maximum you must pay and then insurance will pay 100%. This includes your total deductible as well as your 20% co-insurance payments.