



NEW PATIENT FORM

Name: _____ DOB: _____ Sex: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Mobile Phone: _____
 Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Last Visit Date: _____
 Pharmacy: _____ Pharmacy address: _____

How did you hear about the practice? (Circle one)

Internet/Google _____ Friend/Family _____ Doctor Referral (who?) _____
 Insurance Company _____ Facebook _____ Other _____

Please describe the reason for today's visit. (Include date of injury if applicable)

Is this a work-related injury? YES NO

If yes, please indicate date of injury and brief explanation

PERSONAL MEDICAL HISTORY

Please check all that Applies

<input type="checkbox"/>	Frequent Headache / Migraines	<input type="checkbox"/>	Anemia / Blood Disorders
<input type="checkbox"/>	Rheumatic Fever/ Rheumatoid Arthritis	<input type="checkbox"/>	Ear, Nose, Throat Disorder
<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Drug/ Alcohol Abuse
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Epilepsy / Seizures
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Prostate Disorder
<input type="checkbox"/>	Diseases of the Lungs	<input type="checkbox"/>	Stomach Disorder / Ulcer
<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Thyroid/ Parathyroid Disease
<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Asthma / Hay Fever / Shortness of Breath
<input type="checkbox"/>	BLOOD CLOTS / History of	<input type="checkbox"/>	Psychiatric Treatment
<input type="checkbox"/>	Tumor / Abnormal Growth / Cancer	<input type="checkbox"/>	Emotional Problems / Tension

Do you currently smoke? ___Yes ___No How many years? _____

Did you smoke previously? ___Yes ___No How many years? _____ Year Quit: _____

Please complete the following:

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

Marital Status: ____Single ____Married ____Divorced ____Widowed ____Other

Exercise: Type, duration, frequency (Example: Walking 30 minutes 3x/week)

ALLERGIES

Do you have any allergies to:

_____ Medication: _____

_____ Food: _____

_____ Tapes _____ Novocain _____ Anesthetics _____ Other _____

What types or reactions have you experienced?

MEDICATIONS

Please list all prescription and over- the- counter medications and dosages:

Surgical Procedures/ Serious Injuries/ Illnesses

Family History

Has any family member had any of the following (please indicate relationship)

Cancer _____ Diabetes _____ High Blood Pressure _____

Stroke _____ kidney disease _____ Heart Problems _____

Review Of Systems

Please circle any symptoms you've had in the past 3 months

General

Fever
Chills
Fatigue
Weight Loss/ Weight Gain

HEENT

Headaches
Visual problems
Hearing Problems
Light Sensitivity

Cardiovascular

Chest pain
Palpitations
Dizziness
Swelling of legs
Other _____

Urinary

Painful Urination
Frequent/ Night Urination
Bladder Leakage
Other _____

Musculoskeletal

Joint Pain/ Swelling/ Stiffness
Back Pain
Arthritis
Weakness

Neurological

Numbness
Seizures
Tremors
Paralysis

Psychiatric

Depression
Anxiety
Memory Loss

Endocrine

Heath/ Cold intolerance
Changes in Hair/ Skin
Other

Hematology

Anemia
Abnormal bleeding/ Bruising
Blood clots
Other blood disorders _____

Respiratory

Persistent Cough
Wheezing
Shortness of breath

Gastrointestinal

Difficulty Swallowing/ Chewing
Indigestion/ Heart burn
Abdominal Pain
Change in Bowel Movements

The information provided here is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition with x- ray, examination, or photographs of infections as necessary.

Patient Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name:

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with IL State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. **Fox Valley Foot Specialists** uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized by **Fox Valley Foot Specialists**.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to **Fox Valley Foot Specialists**.
3. I have the right to revoke this authorization at any time by writing to **Fox Valley Foot Specialists**. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. This authorization expires one year from the date of my signature below.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE **Fox Valley Foot Specialists** TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

Signature of patient or representative authorized by law _____

Relationship to Patient _____ Date _____

HIPAA Privacy and Release of Information Authorization

I, _____ hereby authorize Fox Valley Foot Specialists LTD and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Patient Printed Name

Date

Patient Signature

ACKNOWLEDGEMENT AND AUTHORIZATION:

I have read and understand the HIPAA/Privacy Policy for Fox Valley Foot Specialists

I hereby assign my insurance benefits to be paid directly to the healthcare provider

I authorize Fox Valley Foot Specialists to release medical information required to process my claim

I have read and understand the Financial Policy for Fox Valley Foot Specialists

I authorize Fox Valley Foot Specialists to obtain/have access to my medication history

I authorize my provider's office to contact me by mobile phone

Signed_____Date:_____



PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please let our front desk staff know.

- As our patient, you are responsible for all authorizations or referrals needed prior to being treated in our office.
- Unless other arrangements have been made in advance by you, or your health insurance provider, payment for office services are due at time of service. We accept cash, check, debit and credit cards.
- Your insurance policy is a contract between you and your insurance company. We will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have the insurance company pay the doctor directly. If the insurance company does not pay the practice within a reasonable amount of time, we will have to look to you for payment.
- We have made prior arrangements with certain insurance companies to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-payment/co-insurance/deductible portion at the time of service.
- We do not bill to insurance companies with which we do not have a prior agreement. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for any clarification of benefits or additional information prior to services rendered.
- You must inform the office of all insurance changes and authorizations/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- There are certain elective services or surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the procedure.
- For self pay custom orthotics, we require 50% deposit at time of casting/order and the remaining balance is due at date of dispensment.
- Payment Plans- We realize there may be circumstances at times that make immediate payment in full difficult. Please feel free to discuss setting up a payment plan with us.
- Past due accounts are subject to collection proceedings. All costs including but not limited to collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of \$35.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

_____ Please initial to indicate copy was offered and received or declined.



No-Show Policy

We here at Fox Valley Foot and Ankle Specialists, understand that sometimes it is necessary to reschedule or cancel appointments. If you need to cancel an appointment, please contact us as soon as possible so we have the opportunity to offer your appointment to another Patient. Please notify us at least 12 hours prior to your appointment time and we will gladly reschedule your appointment. In the event that a patient has No-Showed for their scheduled appointment a **\$40.00 fee** will apply, and will be charged to the credit card on file.

I understand the terms of this agreement. I understand that I am financially responsible for any charges incurred from no show appointments.

Printed Name: _____

Signature: _____ Date: _____

Email: _____