FOX VALLEY
Foot and Ankle Specialists

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

	Frequent Headache / Migraines		**Anemia / Blood Disorders**
	Rheumatic Fever/ Rheumatoid Arthritis		**Ear, Nose, Throat Disorder**
	Kidney Disease		**Drug/ Alcohol Abuse**
	Diabetes		**Epilepsy / Seizures**
	Gout		**Prostate Disorder**
	Diseases of the Lungs		**Stomach Disorder / Ulcer**
	Chest Pian		**Thyroid/ Parathyroid Disease**
	Heart Trouble		**High Blood Pressure**
	Stroke		**Asthma / Hay Fever / Shortness of Breath**
	BLOOD CLOTS / History of		**Psychiatric Treatment**
	Tumor / Abnormal Growth / Cancer		**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
- Hearling 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 cloths
- Other blood disorders _____

Respiratory
- Persistent Cough
- Wheezing
- Shortness of breath

Gastrointestinal
- Difficulty Swallowing/ Chewing
- Indigestion/ Hearth 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:**_____

FOX VALLEY
Foot Specialists

PATIENT FINANCIAL POLICY

Your undcrs1nndmg of our fin:rncinl pohc,c 1 an csscn11al clement of)our care and 1rcatmcnt If)ou ha,c any quc t,ons. pica c letour fron1 de l,. staff l-110,,

- A our patient., ou arc re pon 1blc for all au1honzat1ons or referral needed pnor to bcmg treated m our of!,cc
- Unless other arr:111gcmcnt ha,c been made in ad,ancc by)ou, or) our health msurancc provider, payment for office en1cc arc dut.: at lime of sen1ct.:We accepl ca h, chccl-, debit and crcdll cards
- Your 111 urancc pohc, 1 a contrncl bct\\CCn)ou and your 111 uranccccompany We wtll file your msur:mcc clmm for , ou if) ou as 1gn the bcncf11s to the doctor In other \\Ords, ;ou a1,rrec to haYe the insurance company pay lhe doctor d1rcctl) If the111sur:mcc compnn) does nol pay 1he practice ,, 1thin a reasonable amount of time, "e ,.ill have to look to) ou for pa, mcnt
- We h:I\c made pnor arr:ingcmcnl ,.,,,thccr1a111 msuranct.:compnmcs 10 accept an assignment of benefits We will bill tho c plans ,, 1th ,, htch"cha, c an agrccmcnl and wtII only require you to pay the co-payment/co-m ur:mce/dcduc11blc por11on at the lime ofsen1cc
- We do not bill to msurancccompamcs,,11h"h1ch "e do not ha,ca pnor agreement. Therefore, all charges for your cnre :rnd treatment arc due at the time of semcc
- All health plans an: not the same and do not cover the same services. In the event your health plan determmcs a cmcc to be "not co,cred". or youdo not have anauthonzat1on, you,, 111 be responsible for tl1c complete charge We "ill attempt to rcnf\ benefits for some specializedscn·ices or referrals; howeYcr, you remain responsible for charges to :in) sen ice rendered Patients arc encouraged to contact their plans for any clarification of benefits or additional mfonna11on pnor to sen'iccs rendered
- You must mfom1the office of all insurance changes and authorizations/referral requirements. In the event the office is not mfonned,) ou"111 be responsible for any charges de111ed.
- There arc ccrt:1111 clcct1rc sen ices or surgical procedures for which we require pre-payment. You will be informed m ad,ancc 1f)our procedure ,s one of those In tl1at event, payment will be due one week prior to the procedure
- For self pa) customorthotics. "e require 50%deposit at time of casting/order and the remaining balance isdue at date of d1spcnsmcnt
- P:i) ment Plans- We realize there may be circumstances at times that make immediate payment in full difficult Please feel fn.-cto discuss sc11111g upa payment plan with us.
- Past due accounts arc subJcct to collection proceedings All costs including but not limited to collectionfees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There ts a service fee of $35.00 for all returned checks Your insurance company does not cover this fee.

Signature of Patient/Responsible Party:_____

Printed rune of Patient/Responsible Party:_____ Date:_____ __

_____Please initial to indicate copy was offered and received ordeclined.