Foot First Podiatry II

Michael H. Warheit, D.P.M.
Erin M. Smielewski, D.P.M.

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

DATE OF BIRTH: _____MARITAL STATUS: _____ SPOUSES NAME_____

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)
HOME PHONE: _____ WORK:_____ CELL:_____

SOCIAL SECURITY #: _____ EMERGENCY CONTACT_____
(NAME) (PHONE)
EMPLOYER:_____ OCCUPATION:_____

EMAIL ADDRESS: _____ PREFERRED PHARMACY: _____

PRIMARY CARE DOCTOR: _____ ADDRESS: _____

IF PATIENT IS A MINOR:

FATHER'S NAME: _____ FATHER'S DOB: _____

ADDRESS: _____ PHONE#_____

MOTHERS'S NAME: _____ MOTHER'S DOB: _____

ADDRESS: _____ PHONE#_____

INSURANCE INFO: POLICY HOLDER INFORMATION (IF DIFFERENT THAN PATIENT)

PRIMARY INSURANCE COMPANY: _____MEMBER ID#_____

POLICY HOLDER'S NAME: _____ DOB #_____

RELATIONSHIP TO PATIENT:_____

SECONDARY INSURANCE (IF APPLICABLE): _____

I have been notified about the HIPAA privacy rules regarding my personal, health, and medical information. This information is available on www.BuffaloGrovePodiatry.com. I may request a copy from the office. My signature acknowledges acceptance of the privacy policies.

I authorize Foot First Podiatry II staff to leave a message about my medical information on voice mail: YES _____ NO _____

I hereby give authorization to be seen & treated by Foot First Podiatry II. I also give authorization to bill my insurance for any/all services rendered at each visit. I assign benefits/payments to go directly to Foot First Podiatry II; I understand I am financially responsible for any/all services provided. If I cannot pay my balance in full for any reason, I will make the necessary payment arrangements with the office. I authorize Foot First Podiatry II to release all information required to ensure payment by my insurance company. My signature will remain on file for all insurance submissions.

Signature _____ Date _____

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CHIEF COMPLAINT

REASON FOR TODAY'S VISIT:_____

DURATION OF PROBLEM/ILLNESS?: _____

HAVE YOU BEEN TREATED FOR THIS CONDITION PREVIOUSLY BY ANOTHER DOCTOR? YES/NO

HEIGHT _____ WEIGHT _____ CURRENT SHOE SIZE _____

MEDICAL HISTORY

Any allergies to Medication? If yes, please list: _____

Please provide a listing of all medications you are currently taking:

_____

_____

Please provide a listing of any/all surgical procedures: _____

_____

Any issues/side effects with Anesthesia? YES/NO Any problems with scarring? YES/NO

Are you currently being treated for any of the following conditions? Please check all that apply…

☐ Arthritis ☐Cancer ☐Diabetes ☐High/Low Blood Pressure ☐Heart Attack/Heart Disease

☐ AIDS/HIV ☐ Asthma/COPD ☐ Headaches/Seizures ☐ Depression/Anxiety ☐ Hepatitis C

Family History: ☐Diabetes ☐Stroke ☐Cancer ☐Arthritis ☐Heart Disease

Are you experiencing any issues/symptoms for the following?

Anemia, blood disorders, excessive bleeding?	YES/NO
History of blood clots?	YES/NO
Arthritis, back pain, old fractures?	YES/NO
Bladder, kidney, prostate?	YES/NO
Chest pains, shortness of breath, COPD	YES/NO
Eyes, ears, nose, throat?	YES/NO
Thyroid issues? GERD?	YES/NO
Headaches, migraines, seizures?	YES/NO
Seasonal allergies, sinus, asthma, bronchitis?	YES/NO
Skin rash, itching, bruising?	YES/NO
Stomach ulcers, stomach pain, GERD?	YES/NO
Sudden weight loss, weight gain?	YES/NO

Do you currently smoke? YES/NO Have you smoked in the past 10 years? YES/NO

Do you consume alcohol? YES/NO If yes, how much per day? _____

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FINANCIAL POLICY

Your clear understanding of our Financial Policy is important in order to maintain our professional relationship. Please take time to review all the information provided. In order to comply with our insurance contracts you are required to update our registration forms once a year. This not only protects our office, but you as the patient. We must ensure that our office is informed of any demographic changes as well as changes in your medical history. Our office is in network with many health plans. However, we recommend that you call your insurance company to ensure that our office is part of your network, and that you understand your coverage before we render any services. Please note: If you do not have your insurance card with you at the time of your appointment, payment in full will be due at time of service.

PPO/HMO patients: We will make every effort to bill your insurance for all services rendered. However, as the member you are responsible for understanding your coverage and benefits. All copayments will be collected at time of service. If you are unable to issue payment, we reserve the right to ask you to reschedule your appointment. You are responsible for any deductibles, co-insurance, non-covered items, etc.

Medicare patients: Our office accepts Medicare assignment. You are however responsible for your deductible and co-insurance. If you present your supplemental insurance we will bill them for any remaining balances not covered by Medicare. Please ensure that you provide us with a copy of your card to avoid any processing delays. In the event that a service or supply is not covered by Medicare, we will inform you before services are provided.

Coding Policy: This office can only code and file a claim for your visits with a diagnosis that has been documented in your medical records. To ask our office to change a diagnosis solely for the purpose of ensuring reimbursement from your insurance carrier is inappropriate and may result in termination from the practice.

Custom Orthotics/DME Items: I understand that custom orthotics cannot be returned for a refund once they have been ordered. Normal wear and tear may be expected inside of the shoe you wear your orthotics in. Our office is **not** responsible for any potential damage to the shoe. Once a Durable Medical Equipment item is dispensed it cannot be returned.

Medical Records Request: We require a notice of 10 business days for copies of Medical Records or X-rays. There may be a nominal fee assessed by our office. A release of medical records must be signed by the patient or responsible party.

Returned Checks: There will be a service fee of $35.00 applied to your account for all returned checks. This fee is not billable to your insurance and therefore will be your responsibility.

Missed appointment: In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to show up for an appointment. If it is necessary to cancel your appointment, we require that you call at least 24 hours in advance.

No Show Policy: A failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". The first time there is a "no-show", late cancellation, or cancellation without a reasonable excuse you will receive a warning. A 2nd occurrence will result in a $50 fee. The 3rd occurrence will be a $50 fee and the patient may be discharged from the practice.

I understand that I am financially responsible for all charges not covered by insurance and I agree that the balance will be paid by credit card, check or cash. Past due balances may be subject to additional fees. Any balances placed with an outside collections agency for non-payment will incur a 30% fee off of the original balance. Any collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office. I understand that I am ultimately responsible for payment for all services. If payment is not received from the insurance carrier or other responsible party in 90 days, I will be billed directly.

Signature _____ Date _____