THE FOOT CARE GROUP

1800 HOLLISTER DRIVE, SUITE 109, LIBERTYVILLE, ILLINOIS 60048
OFFICE 847-362-8848 FAX 847-362-8860

PATIENT INFORMATION:

FIRST (LEGAL) NAME	M.I.	LAST NAME	AGE	DATE OF BIRTH	GENDER M F	MARITAL STATUS S M O

STREET ADDRESS	PHONE #1
CITY STATE ZIP	PHONE #2
SOCIAL SECURITY NUMBER	EMAIL ADDRESS (ONLY USED TO COMMUNICATE ABOUT YOUR CARE)

THE FEDERAL GOVERNMENT ASKS THAT WE COLLECT THE FOLLOWING INFORMATION. PLEASE **CIRCLE** YOUR RESPONSE.

RACE: AMERICAN INDIAN ASIAN BLACK/AFRICAN AMERICAN NATIVE AMERICAN PACIFIC ISLAND WHITE OTHER

ETHNICITY: NOT HISPANIC OR LATINO HISPANIC OR LATINO

PRIMARY SPOKEN LANGUAGE: _____

EMPLOYER NAME/ADDRESSS (INCLUDE CITY, STATE AND ZIP CODE)	EMPLOYER PHONE NUMBER
STREET ADDRESS CITY STATE ZIP	

IS THIS A WORK RELATED INJURY WHICH SHOULD BE BILLED TO WORKMAN'S COMPENSATION? YES ____ NO ____

GUARANTOR INFORMATION (MUST BE COMPLETED IF PATIENT IS A MINOR)

NAME RESPONSIBLE FOR PAYMENT OF ACCOUNT	DATE OF BIRTH	RELATIONSHIP TO PATIENT
ADDRESS IF DIFFERENT FROM ABOVE		PHONE NUMBER

YOUR HEALTH INSURANCE:

PRIMARY INSURANCE COMPANY NAME	POLICY HOLDER'S NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT
SECONDARY INSURANCE COMPANY NAME	POLICY HOLDER'S NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

EMERGENCY CONTACT INFORMATION:

CONTACT NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PLEASE READ AND SIGN THE FOLLOWING:

I DIRECTLY ASSIGN ALL MEDICAL/SURGICAL BENEFITS TO THE FOOT CARE GROUP AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATON NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I FURTHER AGREE THAT A PHOTOCOPY OF THIS AGREEMENT SHALL BE AS VALID AS THE ORIGINAL.

_____ _____

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**

BRIEFLY DESCRIBE THE REASON FOR TODAY'S VISIT: _____

_____

WHEN DID IT BEGIN? _____ **HAVE YOU HAD TREATMENT FOR THIS PROBLEM BEFORE:** YES ___ NO ___

BY WHOM? _____ **WHEN DID IT BEGIN?** _____

HAVE YOU BEEN SEEN BY A PHYSICIAN IN THE LAST YEAR FOR ANY REASON? YES ___ NO ___

EXPLAIN _____

_____

MEDICAL HISTORY:

PRIMARY CARE PHYSICIAN – PLEASE INCLUDE NAME, ADDRESS AND PHONE NUMBER

_____

IS A **REFERRAL REQUIRED** FROM YOUR PRIMARY CARE PROVIDER FOR SPECIALTY CARE? YES ___ NO ___

ARE YOU **CURRENTLY** BEING TREATED FOR:

ARTHRITIS	Y N	DIABETES MELLITUS	Y N	NEUROPATHY	Y N
ASTHMA	Y N	GOUT	Y N	SWELLING OF FEET/ANKLES	Y N
BLEEDING DISORDER	Y N	HIGH BLOOD PRESSURE	Y N	PREGNANT	Y N
CANCER	Y N	HIGH CHOLESTEROL	Y N	OTHER:	
CARDIOVASCULAR DISEASE	Y N	LIVER DISEASE	Y N	OTHER:	
CIRCULATION PROBLEMS	Y N	LUNG DISEASE	Y N	OTHER:	

PLEASE LIST ANY **PAST** MEDICAL CONDITIONS:

_____

_____

LIST ANY **PREVIOUS** SURGERIES: _____

_____

PLEASE LIST ANY MEDICATIONS YOU ARE **ALLERGIC** TO: _____

_____

PLEASE LIST ALL **CURRENT MEDICATIONS** TAKEN ON A DAILY BASIS:

_____

_____

_____

SOCIAL HISTORY:	**CURRENT**	**PAST**	**NEVER**
ALCOHOL			
TOBACCO			
SUBSTANCE ABUSE			

NOTICE OF OFFICE POLICIES

INSURANCE

AS A COURTESY TO OUR PATIENTS, A CLAIM WILL BE FILED ON YOUR BEHALF TO YOUR INSURANCE COMPANY. IF YOU ARE UNABLE TO PROVIDE US WITH YOUR INSURANCE CARD ON THE DATE OF YOUR SERVICE A CREDIT CARD DEPOSIT OF $100 IS REQUIRED. THIS AMOUNT WILL BE REFUNDED ONCE A COPY OF YOUR INSURANCE CARD IS PROVIDED.

ALL CO-PAYMENTS REQUIRED BY YOUR INSURANCE PLAN ARE DUE WHEN YOU ARRIVE FOR YOUR VISIT. PLEASE NOTE THAT WE ARE UNABLE TO WAIVE CO-PAYMENTS AS THIS WOULD PUT US IN VIOLATION OF OUR CONTRACT WITH YOUR INSURANCE COMPANY.

NOT ALL SERVICES ARE A COVERED BENEFIT OF YOUR PARTICULAR INSURANCE PLAN. IT IS IMPERATIVE THAT YOU CHECK WITH YOUR INSURANCE CARRIER PRIOR TO YOUR SCHEDULED VISIT SO THAT YOU ARE AWARE OF ANY POLICY EXCLUSIONS THAT MAY APPLY. PLEASE NOTE BENEFIT INFORMATION IS NOT A GUARANTEE OF PAYMENT. YOU ARE FINANCIALLY REPSONSIBLE, TO PAY IN FULL, ANY "NON-COVERED" SERVICES.

NOTICE OF PRIVACY PRACTICE

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THIS INFORMATION CAN AND WILL BE USED TO:

- CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY
- OBTAIN PAYMENT FROM THIRD PARTY PAYERS
- CONDUCT NORMAL HEALTHCARE OPERATION SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS

I ACKNOWLEDGE THAT I HAVE HAD THE OPPORTUNITY TO REVIEW THE NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE IT'S NOTICE OF PRIVACY PRACTICES FROM TIME TO TIME AND THAT I MAY CONTACT THE OFFICE AT ANY TIME TO OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVACY PRACTICES.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND THAT YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE, THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

PERSONS AUTHORIZED TO RECEIVE INFORMATION ABOUT MY HEALTHCARE

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

YOUR SIGNATURE BELOW INDICATES YOU HAVE READ AND AGREED TO THE ABOVE POLICIES

_____	_____	_____
PATIENT/AUTHORIZED REPRESENTATIVE	RELATIONSHIP	DATE

FOR OFFICE USE ONLY

❑ UNABLE TO OBTAIN PATIENT ACKNOWLEDGEMENT OF THESE NOTICES

DATE:	REASON:	BY: