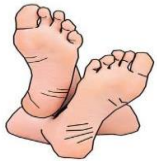


FAMILY PODIATRY

Welcome to our office! Thank you for choosing Family Podiatry ~ Neil B. Levin, D.P.M.

PATIENT NAME _____ **BIRTHDATE**_____
HOME ADDRESS _____ **AGE** _____
CITY _____ **STATE** _____ **ZIP**_____ **SEX M ~ F**

Name you would like us to call you:_____
How did you hear about us?_____ **MARITAL STATUS** *Single ~ Married ~ Other*
YOUR PHONE NUMBERS YOU WANT US TO CALL YOU AT
Primary:_____(appt reminders) Secondary:_____ Work:_____
Email:_____ **Who is your primary physician**:_____

SOCIAL SECURITY # _____
PATIENT'S EMPLOYER/SCHOOL _____OCCUPATION_____
PATIENT'S EMPLOYER ADDRESS_____ PHONE_____

SPOUSE NAME_____SOCIAL SECURITY #_____BIRTHDATE_____
SPOUSE EMPLOYER_____ADDRESS_____PHONE_____

If patient is a minor/who is responsible party:

Name:_____ Relationship _____Birthdate _____ Social Security #_____
Address:_____Phone:_____Sex: M ~ F Employer: _____
Employer Address_____Employer Phone#_____

IN CASE OF EMERGENCY CONTACT
Name_____Relationship:_____Phone:_____

INSURANCE INFORMATION

PRIMARY INSURANCE SUBSCRIBER/ID GROUP
*COMPANY NAME*_____NUMBER_____NUMBER_____

SECONDARY INSURANCE SUBSCRIBER/ID GROUP
*COMPANY NAME*_____NUMBER_____NUMBER_____

ATTENTION: IF YOUR INSURANCE SUSCRIBER IS SOMEONE OTHER THAN YOURSELF PLEASE PROVIDE THE FOLLOWING:

Subscriber Name_____ Birthdate_____
Address_____City_____State_____Zip_____
Phone _____ Social Security #_____Relationship_____
Employer Name & Address_____Phone_____

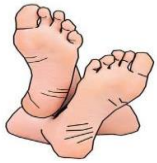
The Federal Government is now asking us to collect this information. Please circle your response:
Race: African American ~ Asian ~ Caucasian ~ Native American ~ Pacific Islander ~ Prefer not to respond

Ethnicity: Hispanic or Latino ~ Not Hispanic or Latino ~ Prefer not to respond

Language: English ~ Spanish ~ Other:_____

It is the policy of our office that **all fees are due at the time services** are rendered either by cash, check or credit *card unless prior arrangements have been made.* We are happy to discuss fees prior to treatment in order to avoid misunderstandings. We are happy to file your claim to your primary and secondary insurance companies. Regardless of insurance coverage, **you are personally responsible for payment of your account**. If you are unable to pay your balance in full after insurance has processed, we require monthly payments to avoid interest charges. I acknowledge the above statement:

Signature X Date:



FAMILY PODIATRY

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Financial Policy-Credit Card Authorization

Paying by credit card is becoming standard practice in healthcare. It is safe, quick and easy! We will be asking you for a credit card at check-in. If any balance is due after your insurance pays it's portion of your services, we will notify you before charging your card.

This practice is safe, green and practical. None of the information associated with your card will be stored in our computer system. Any patient with or without insurance will be asked to provide a credit card at the time of service. This is to cover any amount your insurance does not pay, such as deductible, or non-covered services.

1) At the time of your visit, our staff will have you fill out a credit card authorization form.
2) For your security, we do not store your credit card number in our system. We utilize a secure website for credit card processing and storage, Authorize.net.
3) As a service to our patients, we automatically submit your medical claims to your health insurance company. When your insurance determines the amount that is "patient responsibility", we then will send you one bill. If you have not made contact with us by payment or phone by the next billing cycle, we will then charge the balance to the card you provided.
4) If the information of the credit card you provided changes in any way please contact us ASAP to avoid any issues with your account.

Thank you for your confidence in our office
Dr. Neil Levin and Staff

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with **(name of insurance)**_____
And assign directly to Dr. Neil Levin all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related serviced.

I authorize the release of medical information necessary to process any claim. I authorize payment of benefits either to myself or to Family Podiatry as agreed upon at the time of treatment for services rendered.

_____

Patient Signature (or authorized representative) **Date**

FAMILY PODIATRY

Welcome to our office!   Thank you for choosing Family Podiatry ~ Neil B. Levin, D.P.M.

NOTICE OF COLLECTION POLICY

I understand that in the event any unpaid balance is placed for collections, with any 3rd party collection agency, and/or placed with an attorney to obtain judgment or otherwise satisfy payment of this account, all collection costs, attorney fees, filing fees, interest and court costs will be added to the total amount due.

______________________________ ______________________________

(Patient/Guardian Signature) **(Date)**

~~~~~~

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that 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 operations such as quality assessments and physician certifications.

I have received, read and understand your *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 its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private 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 you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ______________________________

Relationship to Patient: ______________________________

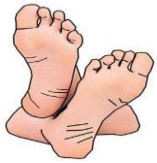
Signature: ______________________________

Date ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
~~~~~~



FAMILY PODIATRY

Welcome to our office! Thank you for choosing Family Podiatry ~ Neil B. Levin, D.P.M.

Neil B. Levin, D.P.M.
1675 Bethany Road, Suite B
Sycamore, IL 60178

Phone: 815-899-2575
Fax: 815-899-2581

Date: _____

I authorize Family Podiatry to charge my **credit/debit** card for:

____ My deductible/coinsurance once my charges have been processed.

____ My open patient balance based on the schedule I indicated below.

____ I plan on making a payment when I get my bill. **(STILL FILL OUT FORM)**

Name: _____

Address: _____

Daytime Phone: _____ Evening Phone: _____

Card Type (check one) VISA _____ MASTERCARD _____ DISCOVER _____

Card Number: _____

Name Listed On Credit Card (If different): _____

Exp. Date: _____ CVV: _____

* I would like the credit/debit receipt mailed to me for each transaction.

YES _____ NO _____

Please charge my card $_____ (amount) every _____ (day/date) of each month until my balance is paid off.

Or indicate you own schedule of payments:

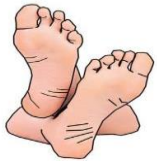
_____

_____

Once the account is paid off we will mail you a statement /printout of your $0 balance.

This authorization may be revoked or changed at any time by contacting our office.

Signature _____ Date:_____



FAMILY PODIATRY

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MEDICAL HISTORY

Patient Name:_____Date:_____

Describe your foot/ankle problem:

_____

_____

CIRCLE YOUR ANSWER AND COMPLETE ANY QUESTIONS WHICH APPLY TO YOU.

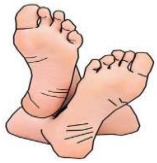
1. **Shoe Size/Width _____ Weight_____ Height_____**
2. **Preferred Pharmacy:_____City:_____**
3. **Have you had any surgeries**? Yes No

   List type and year performed_____
4. **Have you had any foot surgery**? Yes No

   List type and year performed_____
5. Previous Podiatrist:_____ Date of last visit:_____
6. WOMEN are you pregnant? Yes No
7. **Do you use tobacco currently**? Yes No **Have you ever used tobacco**? Yes No
8. Are you being treated for or have you ever been treated for:

Anemia	Yes	No	Gout	Yes	No
Arthritis	Yes	No	Heart Problems	Yes	No
Asthma	Yes	No	/ Type_____		
Auto Immune Disorder	Yes	No	High Blood Pressure	Yes	No
/ Type_____			High Cholesterol	Yes	No
Blood Clots (DVT)	Yes	No	Liver Disease or Hepatitis	Yes	No
Cancer / Type_____	Yes	No	Neuropathy (PVD)	Yes	No
Circulation Problems	Yes	No	Skin Rashes or Hives	Yes	No
Diabetes	**Yes**	**No**	Stomach Ulcers	Yes	No
Emphysema/Lung Disease	Yes	No	Swelling of the feet/ankles	Yes	No
Epilepsy/Seizure Disorder	Yes	No	Thyroid Disease	Yes	No

Other not listed_____



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9. Are you **allergic** to or have you **reacted adversely** to any of the following:

Aspirin	Yes	No	Local Anesthesia	Yes	No
Codeine	Yes	No	Metals	Yes	No
Iodine/Betadine	Yes	No	Penicillin	Yes	No
Latex	Sensitive	Allergic No	Sulfa Drugs	Yes	No
Tape/Bandaids/Adhesive	Sensitive	Allergic No	Other:_____		

Prescription/Nonprescription Medications (if you have a list we can make a copy)

MEDICATION NAME	DOSEAGE/How Often (SUCH AS 2MG, 1 TSP~once a day)	What do you take medicine for?