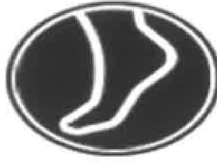


PRAIRIE
FOOT & ANKLE

2371 Bowes Road, Suite 400 Elgin, IL 60123

PATIENT INFORMATION

NAME: ______________________________ SOCIAL SECURITY: _________________

DOB: _______________ SEX: M F PRIMARY PHYSICIAN: _______________________

EMAIL ADDRESS: ____

HOME ADDRESS: ____________________ CITY: ______________ STATE: ____ ZIP CODE: ________

HOME PHONE: __________________ WORK PHONE: _______________ CELL: _________________

MARITAL STATUS (CIRCLE ONE): SINGLE MARRIED DIVORCED WIDOW SEPARATED

(CIRCLE ONE): FT STUDENT PT STUDENT FT EMPLOYED PT EMPLOYED OTHER

EMPLOYER'S NAME: ____

OCCUPATION: ____

PERSON RESPONISBLE FOR PAYMENT, IF NOT PATIENT

IF PATIENT IS A MINOR, PLEASE ENTER RESPONSIBLE PARTY INFORMATION **(THE ADULT PRESENTING THE MINOR FOR CARE IS THE RESPONSIBLE PARTY. WE CANNOT SEE MINORS WITH AN ABSENT PARENT/GUARDIAN).**

NAME: ____

SOCIAL SECURITY NUMBER: ______________________________________

ADDRESS: ____

CITY: _________________________ STATE: ___________ ZIP CODE: ___________________

HOME/CELL PHONE: ____________________________ WORK: _________________________________

EMPLOYER: ______________________________ OCCUPATION: ___________________________

RELATIONSHIP TO PATIENT: ____

POLICY HOLDER (if different from patient or person responsible for payment):

POLICY HOLDER NAME: ________________________________ DATE OF BIRTH: ________________________

SOCIAL SECURITY NUMBER: ____

ADDRESS: _____________________________________ CITY: ________________ STATE: _____ZIP: ____________

EMPLOYER NAME: ___________________________________ OCCUPATION: ________________________________

HOME/CELL PHONE: __________________________________ RELATIONSHIP TO PATIENT: ______________________

HOW DID YOU HEAR ABOUT OUR PRACTICE?

(CIRCLE ONE): PHYSICIAN PHONEBOOK INSURANCE INTERNET WEBSITE OTHER

REFERRING DOCTOR NAME: ____

PREFERRED PHARMACY: ____

CO-PAY AMOUNT: _____________________

PREFERRED LANGUAGE (CIRCLE ONE): ENGLISH SPANISH OTHER: _________________________

INTERPRETER NEEDED (CIRCLE ONE): YES NO

ETHNICITY (CIRCLE ONE):

WHITE NATIVE AMERICAN OTHER

HISPANIC ASIAN REFUSED

AFRICAN AMERICAN NATIVE HAWAIIAN

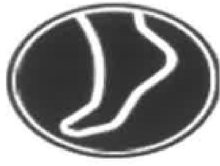
EMERGENCY CONTACT INFORMATION:

NAME: ____ PHONE: ______________________________________

RELATIONSHIP: ____

IS THIS A WORKMAN'S COMPENSATION CASE (CIRCLE ONE): YES NO

FOR OFFICE USE ONLY: ENTERED BY: ____________________________ *DATE:* _________________________________



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TREATMENT CONSENT:

I hereby authorize and consent to treatment at Prairie Foot & Ankle. This may include the administration of medication, diagnostic test, and procedures as deemed necessary by my physician, or his assistants or designees, for the purpose of diagnosis or treatment.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize payment to Prairie Foot & Ankle for any services rendered by the practice after this date, and for such other charges as may be made by said practice. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that health insurance coverage varies and is not a guarantee of benefits and that not all services provided may be covered. It is my responsibility to negotiate payments from the insurance company and while they use such terms as customary, reasonable, prevailing, usually, etc. to limit their coverage, payment of the office charges remains my obligation.

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY:

I understand that I will be responsible unless otherwise specified in another written contract, for all services rendered to the patient. I agree to pay for service rendered, in full at time of service, unless other arrangements are made in advance with this office. Whether or not I have insurance, I as a patient/guarantor am responsible for the charges for services rendered to the patient. I further understand that I will be responsible for any additional charges for services which may not be available at the time of leaving the office. I agree to pay for any attorney fees or collection fees that result of the pursuit of collection for services rendered.

AUTHORIZATION TO RELEASE INFORMATION:

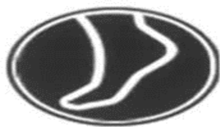
I hereby authorize Prairie Foot & Ankle to release any and all information to insurance companies or associations, employee groups, employer, government agencies or their third party payers and their agents or employees, either by mail or electronically, as may be necessary for the completion of all claims. If said records should be received by another party in error, I absolve the practice of any liability related to such submission of said records.

_______________________________ _______________________

Patient Signature Date

____

Guardian Signature Date



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PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or manager.

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept Visa, MasterCard, Discover, cash or check.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you, if you assign your benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

We have made prior arrangements with certain Insurers and other health plans to accept an assignment of benefits. We will bill plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.

If you have Insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. 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 clarification of benefits 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.

All deductibles & co-pays are collected at time of visit.

***Missed appointments may result in charges.**

We request at least 48 hours' notice for missed appointments or you may be charged $30.

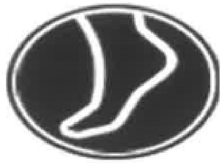
For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees, and court fees shall be your responsibility. In addition to the balance due at the office.

There is a service fee of $25 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: ____

Printed Name; ____ Date: __________________________



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I, ____, am aware that I have a high deductible and co-insurance and will be responsible for any office charges for today's visit.

I was given two options at today's office visit.

Initials: ________ 1. Choose to be self-pay, and not have this visit billed to my insurance.

Initials: ________ 2. Choose to pay insurance rates today. I acknowledge that claims will be billed to insurance and amount applied to deductible. If there is an overage a refund will be issued.

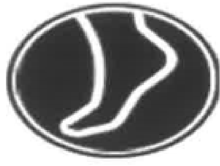
I understand and agree to the above information.

Patient Signature: ____

Date: _____________________________

Witness: ____

Date: _____________________________



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RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I, ____________________, hereby acknowledge receipt of the physicians' Notice of Privacy Practices. The Notice of Privacy Practices details information about how the practice may use or disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available via a posting in the reception are of Prairie Foot & Ankle.

Signed: ____ Date: ____________________

If you are not the patient, please specify your relationship with the patient: _________________

At times, the physician, assistant, or nursing staff often need to speak with you regarding a medical issue. Please assist our medical staff by telling them where and with whom they can leave any messages regarding medical issues. I authorize the staff of Prairie Foot & Ankle to contact me via:

_____________ Home answering system or voicemail

_____________ My Cell Phone# __________________________

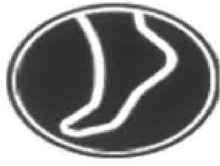
_____________ My Work Phone# __________________________

_____________ Leave only a request for me to call back

_____________ Ok to speak with _______________________regarding any reason for your call.

Patient Signature: _________________________________ Date: _________________________

Parent/Guardian Signature: _____________________________ Date:_____________________



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SUMMARY OF NOTICE OF PRIVACY PRACTICES

The following information is a summary of **NOTICE OF PRIVACY PRACTICES. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.**

We are required by law to maintain the privacy of your medical information. We must provide you with a copy of this notice. We must follow the terms of this notice. If the notice is changed in any material way, a revised notice will be available upon request.

We will use your medical information:

Treatment. For example, a nurse or medical assistant who is providing your care will report any changes in your condition to your doctor. We will use your medical information for **payment.** For example, we may need to give your insurance plan information about your diagnosis, treatment, and supplies used. We will use your medical information for **Health Care Operations**. For example, we may use your medical information to evaluate our services. We may contact you at any phone number or address you have provided to us to remind you of an appointment or other health care matter or to obtain payment for our services.

We may use your medical information for any uses that are required or permitted by law.

Other non-routine uses, and disclosures will be made only with your written authorization. You may cancel an authorization at any time by notifying the clinic in writing.

You have the following rights: **Right to receive the privacy notice; Right to request restrictions on uses and disclosures of your medical information; Right to receive confidential communications; Right to inspect and copy your medical information; Right to request an amendment to your medical information; and Right to an accounting of disclosure of your medical information.**

If you feel that your privacy rights have been violated, please contact the physician in the office or the U.S. Secretary of Health and Human Services.

Patient Signature: ______________________________ Date: ______________________