

SUBURBAN FOOT & ANKLE ASSOCIATES15724 S. Route 59 * Unit 100
Plainfield, IL 60544215 Remington Blvd * Unit A2
Bolingbrook, IL 60440Patient Name: _____ Sex: Male Female

Soc. Sec.#: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Height: _____ Weight: _____ Shoe Size: _____

Race/Ethnicity: American Indian/Alaska Native Asian Black/African American White/Caucasian Hispanic/Latino More than one race Native Hawaiian Pacific Islander Choose not to reportMarital Status: Single Married Widowed Separated Divorced

Employer: _____ Employer Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____

In case of emergency contact: _____ Relationship: _____

Emergency Contact Number(s) That Is Different From Patient: _____

INSURANCE

Primary Insurance Company: _____

ID# _____ Group#: _____

Insured Name: _____ SS# _____ Date of Birth: _____

Secondary Insurance Company: _____

ID# _____ Group#: _____

Insured Name: _____ SS# _____ Date of Birth: _____

How did you hear of us? Doctor _____ Phone Book Friend ER Family Insurance Website Hospital Internet Other: _____**Primary Care Physician / Specialist Information**

Primary Care Physician: _____ Date Last Seen: _____

Did your primcary care or specialist refer you? Yes NoIf Yes: Primary Care Specialist Dr. _____Are you currently under the care of any other specialist? Yes No

If yes, please list: _____

I hereby give permission for Dr. Basile to render the proposed Podiatric examination and treatment. I authorize the release of any information to my insurance company and any medical information necessary to process any claim and I request payment of insurance benefits due to Suburban Foot & Ankle Associates to be paid directly to Suburban Foot & Ankle Associates.

I hereby give my permission for Suburban Foot & Ankle Associates to forward any pertinent medical information to my primary or referring physician for continuity of care.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time by either myself or my insurance company in writing.

The above information is true and I will notify Suburban Foot & Ankle Associates of any changes.

Signature: _____ Date: _____

Suburban Foot & Ankle Associates
Patient Clinical Information

Allergies or adverse reactions: **No Known Drug Allergies**

- | | | | | |
|------------------------------------|------------------------------------|-------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Local Anesthetics: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Novocaine | <input type="checkbox"/> Tape | <input type="checkbox"/> Latex | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cortisone | <input type="checkbox"/> Demerol: | <input type="checkbox"/> Penicillin | | <input type="checkbox"/> Other: _____ |

Please indicate any of the following:

- | | | | | |
|---|--|---------------------------------------|---------------------------------|---------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> COPD | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Ulcers | <input type="checkbox"/> CAD |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> PVD | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> SOB | <input type="checkbox"/> HOH | <input type="checkbox"/> Other: _____ |

SURGERIES: List year and reason

MAJOR DISEASE:

- | | | |
|---------------------|-------------------------------|---------------------------------|
| Diabetes | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| High Blood Pressure | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Angina | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Heart Disease | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Heart Attack | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Aids/HIV | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Stroke | <input type="checkbox"/> Self | <input type="checkbox"/> Family |

CARDIOVASCULAR:

- | | | |
|-----------------------------|-------------------------------|---------------------------------|
| Anemia | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Bleeding Disorders | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Poor Circulation | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Peripheral Vascular Disease | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Swelling of feet/Ankle | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Phlebitis | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Leg pain when walking | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Anticoagulation Therapy | <input type="checkbox"/> Self | <input type="checkbox"/> Family |

FOOT PROBLEMS:

- | | | |
|-------------------|-------------------------------|---------------------------------|
| Ankle Pain | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Bunion | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Corns / Callouses | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Flat Feet | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Heel Pain | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Ingrown Toenails | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Plantar Warts | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Plantar Fasciitis | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Tired Feet | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Other: _____ | <input type="checkbox"/> Self | <input type="checkbox"/> Family |

NERVOUS:

- | | | |
|----------------------|-------------------------------|---------------------------------|
| Numbness | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Headaches | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Seizure / Convulsion | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Paralysis | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Loss of Feeling | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Depression | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Anxiety | <input type="checkbox"/> Self | <input type="checkbox"/> Family |

MUSCULO-SKELETAL:

- | | | |
|---------------|-------------------------------|---------------------------------|
| Arthritis | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Joint Disease | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Fractures | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Gout | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Fibromyalgia | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Sciatica | <input type="checkbox"/> Self | <input type="checkbox"/> Family |

HEENT:

- | | | |
|-----------------------|-------------------------------|---------------------------------|
| Difficulty Swallowing | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Eye Problems | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Hearing Problems | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Ear Problems | <input type="checkbox"/> Self | <input type="checkbox"/> Family |

RESPIRATORY:

- | | | |
|--------------|-------------------------------|---------------------------------|
| Asthma | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Bronchitis | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Lung Disease | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Tuberculosis | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Ephysema | <input type="checkbox"/> Self | <input type="checkbox"/> Family |

Please describe the condition for which you are being seen today.

When did this problem begin?

Have you seen a doctor for this? If yes, who:

How have you treated it so far?

Is this condition due to an injury? If so, when?

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis/treatment of my feet/ankles.

Patient / Responsible Party Signature: _____ Date: ____/____/____

Patient Name: _____ **Date of Birth:** ____/____/____

PATIENT CONTRACT

- 1) Payment is expected at time of service. **EXCEPTIONS** to include: Medicare patients, PPO and HMO members.
- 2) As a courtesy, we will be happy to bill your primary and secondary insurance company on your behalf. It is up to each patient to know the rules and limitations of your policies.
- 3) You are responsible for any portion not covered by your insurance, such as deductible and/or copay. This amount is due at the time of service.
- 4) If your insurance company does not make the payment you expect, it is up to the policyholder to contact the insurance company. Our office will supply any documentation necessary to expedite the handling of the claim. Please read your explanation of benefits to determine amounts owed.
- 5) Any balance past 60 days is considered delinquent, and will be put to patient responsibility.
- 6) Most insurance companies **do not cover supplies** given from an office setting; payment will be due at the time of service for such supplies (**ABN SIGNATURE WILL BE REQUIRED**). We will attempt to bill these supplies to your insurance company and refund any money received to you.
If you need to cancel an appointment, please notify us at least 24 hours in advance. We will gladly reschedule your appointment.
- 7) A collection fee of 20% will be applied to any outstanding balances that are delinquent over 90 days or submitted to a collection agency.

FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

COPAYMENTS: by law we must collect your carrier designated copay at the time of service.

REFERRALS: if plan requires a referral from your PCP it is your responsibility to obtain it prior to your appointment.

NON PLAN PATIENTS: Payment is expected at time of service.

MEDICARE: we will submit to Medicare for the entire Medicare allowed amount. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed directly to secondary insurance if you have one.

We accept CASH, CHECK, MASTERCARD, DISCOVER AND VISA.

I have read and understand the above Patient Contract and Financial Policy for Suburban Foot & Ankle Associates.

Signature of Patient, Parent or Legal Guardian _____ **Date:** ____/____/____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I request that all confidential communication to me from Dr. Basile, Dr. Mohammed and staff at Suburban Foot & Ankle Associates be handled in the following manner: **Check all that apply**

Written communication:

- to my home address to a different address _____
 to my email address _____

Telephone communication: May leave message on;

- home number cell phone different number _____
 with family member answering machine voice mail

Test Results:

- May only release test results to myself
 May leave with results with spouse

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I acknowledge that I was provided a copy of the Notice of Privacy Practices from Suburban Foot & Ankle Associates and that I have read (or had the opportunity if I so choose) and understand the Notice

Patient / Responsible Party Signature: _____ Date: ____/____/____

Credit Card Authorization Form

By signing below, I am hereby authorizing **Suburban Foot & Ankle Associates** to charge my credit/debit card for any account balances put to my responsibility as outlined in my Insurance policy and benefits. This payment will be deducted on the 15th of every month.

Card Type: () Visa () MasterCard () Discover

Card Number: _____

Expiration Date: ____/____/____ Security Code: _____

Cardholders Name: _____

Cardholders Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Cardholders Signature

Date

Office Personnel:

Patient Name: _____

SFAA Account Number: _____