PATIENT DEMOGRAPHICS

First: _____M.I._____Last: _____Birthdate: _____

Billing Address: _____ City, ST, ZIP: _____

Cell Phone #: _____ *Home / Work* (Circle) #: _____

E-Mail (To Access Your Patient Portal): _____ SSN *(Required):* __ __ __ - __ __ __ - __ __ __ __

Sex (Circle): *MALE / FEMALE* Marital Status: _____

Race: _____ Ethnicity (Circle): *Hispanic / Non-Hispanic* Primary Language: _____

Primary Care Physician: _____ Referring Physician: _____

Preferred Pharmacy Name & Location: _____

Emergency Contact *(Required):* _____ Phone: _____Relationship: _____

EMPLOYMENT INFORMATION

Occupation: _____Employer/Contact #: _____

INSURANCE/BILLING INFORMATION

(Who should be billed for today's visit? – CIRCLE ONE BELOW)

Private Insurance / Work Camp / Motor Vehicle Accident / Third Party Liability

Primary Insurance*:* _____

Guarantor Person: _____ Relationships: _____

Guarantor SSN *(Required):* _____ DOB: _____

Secondary Insurance*:*_____

*Guarantor Person:*_____ *Relationship:*_____

Guarantor SSN (Required): _____ *DOB:* _____

MEDICATION LIST

List all medications you are taking (include those you take without a prescription) or provide the receptionist with a medication list.

Medication	Dosage	Reason

ALLERGIES

PRESENT CONDITION

Height	Weight
Briefly describe the reason for your visit:	
Have you seen any other physicians for this condition?	If so, by whom and when?

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, hereby authorize McLean County Foot & Ankle to use or disclose all of patient's medical information including but not limited to Report of Procedures, History and Physical, Progress Notes, (called "protected health information") to its staff and other health care providers as is necessary by McLean County Foot & Ankle for the purpose of carrying out treatment, payment of the services provided to the patient or health care operations.

"Health care operations" refers to a large number of activities, including:

1. Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
3. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
4. Business planning and development, such as conducting cost management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
5. Business management and general administrative activities including but not limited to: (a) management activities relating to HIPAA privacy rule compliance; (b) customer services, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer; (c) resolution of internal grievances; (d) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and (el creating de-identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required.

"Payment" means the activities undertaken by the physician to obtain reimbursement for the provision of healthcare. The activities referred to in this definition relate to the individual to whom health care is provided and include, but are not limited to:

1. Determination of eligibility coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
2. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing;
3. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
4. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
5. Disclosure to consumer reporting agencies of any of the following information relating to reimbursement; name and address, date of birth, Social Security number, payment history, account number, and name and address of physician.

(Insert name of person(s) who may receive the information below)

Name: **Relationship:**

Name: **Relationship:**

I also authorize McLean County Foot & Ankle to leave messages on my answering machine which may contain protected health information.

I acknowledge receipt of the McLean County Foot & Ankle's Notice of Privacy Practices. The Notice of Privacy Practice providers detailed information about how the practice may use and disclose my confidential information. I understand that McLean County Foot & Ankle has reserved a right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or rnade available by our website at http://www.mcleancountyfootandankle.com or by stopping by our office to pick up a copy.

I understand that, as set forth in McLean County Foot & Ankle Privacy Notice I have the right to revoke this authorization, in writing, at any time by sending WRITTEN notification to: (105, Attention: Privacy Office, 1S05 Eastland Drive, Suite 220, Bloomington, Il. 61701. I understand that a revocation is not effective to the extent that the McLean County Foot & Ankle has relied on my consent to use or disclosure the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

PAYMENT AGREEMENT/CONSENT /INSURANCE ASSIGNMENT/RELEASE

In consideration of the medical services provided to and/or treatment of the "Patient" by " McLean County Foot & Ankle ", the person(s) signing this agreement (Signer) agrees to the following:

AGREEMENT TO PAY: The Signer promises to pay, to the extent not paid by the Patient's insurer or other third party payer, McLean County Foot & Ankle 's actual charges for goods and services provided to the Patient. If (105 has agreed to accept payment for services provided to the Patient under a different contract such as, but not limited to Medicare, Medicaid, or a Preferred Provider Agreement, then the foregoing provisions shall not apply, and the Signer shall pay the amount which is the responsibility of the Patient under such separate contract.

GOODS AND SERVICES: The Signer acknowledges that the Patient will receive goods and services from the McLean County Foot & Ankle during the visit as ordered by the Patient or the Patient's physician. Payment for all such goods and services shall be made as provided above.

PAYMENTS: The Signer agrees to pay the full balance of the Patient's account within thirty (30) days from the date of first billing unless McLean County Foot & Ankle in writing approves other arrangements for payment. McLean County Foot & Ankle may in its sole discretion allow additional time for insurance payments to be received and applied to the Patient's account; however, McLean County Foot & Ankle does not waive its right to collect its unpaid billings thirty (30) days after the billing first becomes due.

ASSIGNMENT OF BENEFITS: The Signer hereby irrevocably assigns to (105 all rights, which they have against any insurance company or other third party for payment of the Patient's bill to 1505 Eastland Drive Suite 250 Bloomington, IL 61701. The Signer authorizes the application of any overpayment to any unpaid bill at McLean County Foot & Ankle. The Signer further authorizes *his/her* attorney to remit to McLean County Foot & Ankle proceeds from any Settlement or Judgment made or received on the Patient's behalf to pay any balances due on the Patient's account.

COLLECTION COSTS: The Signer further agrees to pay and be responsible for all collection costs including collection agency fees and reasonable attorney's fees, costs, and courts costs, as well as any other expenses that may be incurred by McLean County Foot & Ankle in collecting any unpaid bill which the Patient incurred for services rendered by McLean County Foot & Ankle.

RELEASE OF INFORMATION: The Signer hereby consents that relevant information on the Patient's medical record and (when specifically requested) copies of any pertinent medical record information may be given to any insurance company or other third party payer for the sole purpose of securing payment of the Patient's bills. The signer further consents that (105 may access and retrieve credit information regarding the Patient and the Signer from any licensed credit bureau.

MISCELLANEOUS: If the Signer is not the Patient, the Signer represents and warrants that they have full legal authority to sign this agreement on behalf of the Patient. All individuals signing this Agreement as the Signer shall have joint and several liabilities for all amounts due hereunder. If the Signer fails to make any payment when due, McLean County Foot & Ankle may at any time thereafter, without notice or demand, declare the entire unpaid balance of the account to be immediately due and payable. This Agreement and the obligations, consent, and information releases contained herein shall be binding upon the Patient's heirs, executors, and administrators.

WORKER'S COMPENSATION

I understand that I am responsible for any charges incurred due to the treatment of my medical condition. In addition, I also understand that McLean County Foot & Ankle, will make a diligent attempt to retrieve payment for services provided to me from the workers' compensation insurance company in cases that have been deemed to be covered by workers' compensation insurance. If my case is not deemed to be covered by workers' compensation insurance, I understand I am expected to follow the guidelines set forth in the "Payment Agreement/Consent/Assignment/Release" section of this form. Finally, I understand that should the settlement for my workers' compensation case take longer than 6 months to resolve, McLean County Foot & Ankle will expect my account to be paid in full within 30 days of the first statement I receive requesting payment on my account unless other arrangements for payment are approved by McLean County Foot & Ankle in writing.

CANCELLATION POLICY

In order to provide the best care and service to our patients, we ask that you notify us 24 hours in advance to cancel/reschedule your appointment. Failure to do so will result in a missed appointment fee of $20.00.

We value our patient/doctor relationships and will do everything we can to accommodate you. Your communication and compliancy are not only very much appreciated but will help us to help you (and others) achieve a positive outcome.

INFORMED CONSENT FOR PRESCRIPTION MEDICATION

1. I agree to take medications only as prescribed and to contact my physician before making any changes.
   -I understand that increasing my dose without the close supervision of my physician could lead to drug overdose causing severe sedation, respiratory depression and death.
2. I will not request or accept controlled substance medications from any other physician or individual while I am receiving such medications from my physician at McLean County Foot & Ankle.
3. I am aware that the following side effects are related to prescribed medications: nausea, drowsiness and constipation. Less common side effects are mental slowing, flushing, sweating, itching, urinary retention and tremors. If these side effects were to occur, they would occur at the beginning of my treatment and would likely go away within 2 weeks without treatment. It is my responsibility to notify my physician of any side effects that continue or are severe (such as sedation or confusion).
4. I am also responsible for notifying my physician immediately if I: -visit another physician or emergency room due to pain
   -become pregnant
   -need to change pharmacies
5. I understand that the medication is strictly for my own use. The prescribed medication should never be given to others. The medication should be placed in a cool, dry area for storage, and, if children are in the house, a childproof top is necessary.
6. I am responsible for my prescribed medication. I understand that refill prescriptions: -can only be written for a one-month supply.
   -must be filled at the same pharmacy where the original prescription was filled
   -require me to call 48 hours in advance to schedule pick-up for my prescriptions
7. If my medication is stolen I must report this to the local police department and obtain a stole item report. Replacement prescriptions will be given at the discretion of the physician. No replacement of medication will be given without a police report.
8. I understand the goals of my physician's treatment plan may include medications for pain and/or infection. If it appears to the physicians that the prescribed medication is not helping with the condition and/or conflicting with daily function, then it is McLean County Foot & Ankle 's responsibility to refer me to a Pain Management Center.
9. I further understand that if I do not follow any of the above conditions or provisions, I may (at my physician's discretion) no longer receive any type of prescribed medication. I also understand that if I have a problem/question with any of the above stipulations, I must make an appointment to discuss this with my physician and receive clarification before a problem or crisis arises.
10. I understand that if I fail to comply with my physician's treatment plan, my physician may choose to discharge me from the practice.

NOTICE TO SIGNER: Do not sign this agreement before you read it. All terms and conditions of this agreement shall be legally binding upon the signer and patient for any present or future services provided to the patient by McLean County Foot & Ankle.

Signed: _____ Print Name: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____