First Name:_____ M.I._____ Last:_____

Date of Birth:_____ Sex:_____ Marital Status:_____Race:_____

Billing Address:_____ City, ST, ZIP:_____

Cell Phone #:_____ Home/Work #:_____

Email (to access patient portal):_____

Primary Care Physician:_____

Preferred Pharmacy Name & Location:_____

Emergency Contact Name:_____ Phone:_____Relationship:_____

Employment:_____ Position:_____

How did you hear about us? Family/Friend Newspaper/Internet Other:_____

Who should we bill for your visit today? (Circle One)

Private Insurance / Work Comp / TPL / Motor Vehicle Accident

Primary Private Insurance:_____

Guarantor Person:_____ Relationship:_____

DOB:_____

Secondary Insurance:_____

Guarantor Person:_____ Relationship:_____

DOB:_____

Medications:

List ALL medications you are taking, including over the counter.

Name	Dosage	Reason

Allergies:

Height: _____ **Weight**: _____ **Shoe Size**: _____

Foot Problems:_____

Where:_____ **How Long:**_____ **days/wks/mos/yrs**

Pain Scale (1-10):_____ **Describe pain:**_____

Aggravated by: walking | standing | shoes | physical activity | Other:_____

Cause of foot problem: injury | deformity | unknown | Other:_____

Treatment in the past:_____

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 & 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 outcomes 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 relation 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 healthcare 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 policyholders, 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 (e) 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:

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 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 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 made available by our website at 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: McLean County Foot & Ankle 3801 G.E. Road, Suite 4 Bloomington, IL 61704. I understand that a revocation is not effective to the extent that McLean County Foot & Ankle has relied on my consent to use or disclosure of 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 actual charges for goods and services provided to the Patient. If McLean County Foot & Ankle 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 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 with 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 all rights, which they have against any insurance company or other third party for payment of the Patient’s bill to 3801 G.E. Road, Suite 4 Bloomington, IL 61704. The Signer authorizes the application of any overpayment to any unpaid bill at Mclean County Foot & Ankle. The Singer further authorizes his/her attorney to remit to McLean County Foot & Ankle proceeds from any Settlement or Judgement 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 court 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 Mclean County Foot & Ankle my 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 heir, executors, and administrators.

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, or 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 stolen 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 physician 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:_____

Patient Appointment and No Show Policy

At McLean County Foot & Ankle we value our relationships with our patients and understand your time is valuable. With that in mind, we work to maintain the most efficient schedule and make every attempt to get patients an appointment within a reasonable timeframe. We appreciate your understanding of and adherence to our policy.

McLean County Foot & Ankle utilizes scheduled patient appointments and does not accept walk-in visits. We also understand that schedules sometimes change. Our office sends automated voice message reminders for provider appointments. In the event, you do not receive this message, you are still responsible for no show fees in regards to missed appointments. If you are unable to keep a schedule appointment, we ask that you call us at least 24 hours in advance to reschedule.This allows us to reschedule your cancelled appointments in a timely manner and allows other patients with urgent needs to quickly access our provider. If you do not call to cancel or reschedule before your scheduled appointment time, it is documented as a NO SHOW. You will be notified via our automated messaging system of the no show. You will need to call our office to schedule another appointment.

The following outlines our policy for NO SHOWS:

1. **First Occurrence: Notified via automated message and assessed a $25 NO SHOW FEE.**

2. **Second Occurrence: Notified via automated message and assessed an additional $25 NO SHOW FEE. No more patient appointments will be scheduled until the NO SHOW FEES are paid in full.**

3. **Third Occurrence within a 24 month period: If you no show 3 appointments with a 24 month timeframe, you will be dismissed from the practice and be assessed an additional $25 NO SHOW FEE.**

NO SHOW fees will be billed directly to you, the patient. This fee is not covered by insurance, and must be paid prior to your next appointment.

Because it is important to keep our appointments on time and not make patients wait longer than necessary, patients arriving more than 15 minutes late for a scheduled appointment may be rescheduled for another day.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

My signature below constitutes acknowledgement and acceptance of this policy.

_____ _____

Patient or Guarantor Signature Date

_____

Print Patient's Name