

Ankle & Foot Centers of Elmhurst and AnkleNFootCenter.com

Dr. George Tsatsos, D.P.M., F.A.F.S., F.A.C.F.O., · Dr. Svetlana Zats, D.P.M., A.A.C.F.A.S.

401 N. York Rd., Elmhurst, IL 60126 (630) 530-5757 • 2220 W. Belmont Ave., Chicago, IL 60618 (773) 348-7500

PATIENT INFORMATION:

Chart#: _____

First: _____ **M.** _____ **Last:** _____

Date of Birth: _____ **Social Security #:** _____

Sex: Male ___ Female ___ **Marital Status:** Married ___ Single ___ Widowed ___ Divorced ___ Separated ___ Minor ___

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Okay to leave message:** Y ___ N ___ (Check One)

Guardian Name (if minor): _____ **Relation:** _____

Cell Phone: _____ **E-mail Address:** _____

You may speak to the following person/people regarding my treatment (list name and relation): Only Myself ___

Emergency Contact: Name _____ **Phone** _____

Referral Source (how did you hear about us?): _____ **YP page #:** _____

Patient Employment: Full Time ___ Part Time ___ Retired ___ Self- Employed ___ Unemployed ___ FT Student ___ PT

Student ___

Patient Employer Name: _____

Phone: _____

Employer Address, City, St, Zip: _____

Occupation: _____

INSURANCE INFORMATION: **Self Pay:** ___ **Workman's Comp related?:** Y ___ N ___

Primary Insurance Co Name: _____ **Phone#** _____

ID #: _____ **Group #:** _____

Insured Name: _____ **Relationship to Insured:** Self ___ Spouse ___ Child ___ Other ___

Please fill in Insured Information if the Patient is NOT the Insured

Insured Social Security #: _____ **Date of Birth:** _____

Employer Name: _____ **Work Phone:** _____

Employer Address: _____

Secondary Ins Co. Name: _____ **Phone#** _____

ID #: _____ **Group #:** _____

Insured Name _____ **Relationship to Insured:** Self ___ Spouse ___ Child ___ Other ___

Please fill in Insured Information if the Patient is NOT the Insured

Insured Social Security #: _____ **Date of Birth:** _____

Employer Name: _____ **Work Phone:** _____

Employer Address: _____

Signature below validates the above information and authorizes and agrees to the following :

Signature of Patient/Insured/Claimant

Date

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MEDICAL INFORMATION/ HISTORY:

Patient Name: _____ **Chart#:** _____

1. Primary Foot Complaint: _____
2. First date of symptoms: _____ Accident Related?: Y / N
3. What is your: Height _____ Weight _____ Shoe Size _____
4. Women: Do you wear heels regularly? _____ How high? _____
5. Are you now, or have you been under a physician's care during the past two years? Yes ___ No ___

If so for what reason (s): _____

Physician Name: _____ Phone _____

Phys.Address _____

6. List all Current Medications **with dosages** (including food/health supplements): _____

7. Have you ever experienced any effects or allergic reactions from the following? No Known Allergies ___
Novocain ___ Codeine ___ Penicillin ___ Other Medications or Foods _____

8. Are you subject to prolonged bleeding? Yes ___ No ___

9. How would you rate your Health? Excellent ___ Good ___ Fair ___ Poor ___

10. Do you **or** a blood relative have a history of any of the following?

	<u>Self</u>	<u>Family (who)</u>	<u>N/A</u>		<u>Self</u>	<u>Family (who)</u>	<u>N/A</u>
Heart Conditions	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>
Liver Problems	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	Other _____			

11. List **all** serious illnesses, injuries or surgeries (please include dates):

12. Are you now or have you ever been a smoker? Yes ___ No ___ Amount: _____

If you quit, when and how long did you smoke? _____

13. Do you consume Alcohol? Yes ___ No ___ Amount: _____

Signature below validates the above information and authorizes and agrees to the following:

I give permission to Dr. George Tsatsos and/or his Associates to administer treatment; and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle condition(s).

I have received a copy of the NOTICE OF PRIVACY PRACTICES and financial policies of Ankle and Foot Centers and understand my patient rights and obligations.

I authorize ankle & foot center representatives to speak to other doctors or representatives to obtain any information needed for my treatment or processing of claims.

Signature of Patient OR Legal Guardian (if patient is a minor)

Date

Welcome to Our Practice!

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Thank you for choosing our office to serve your podiatric needs. We welcome you and hope that you will be greatly satisfied with our services. Below is a detailed description of our office and financial policies – you should **retain this copy for your records.** Should you have any questions or concerns please do not hesitate to speak to someone in our front office.

1. **Please give 24 hours notice of appointment cancellation.**
If you fail to give notice, we will charge your account a \$25 missed appointment fee.
2. **Kindly inform our office staff of any changes in your personal or medical information. Including:**
 - a. Address and/ or telephone numbers.
 - b. Insurance Information
 - c. Changes/additions in medications
 - d. Allergic reactions to medications or food
 - e. Any new symptoms you may be having
3. **Our office requires a copy of your insurance cards along with a copy of an identification such as State of Illinois Drivers License, State ID or other federal/state/county issued identification.**
4. **Know your own Insurance Plan Benefits**
As a courtesy to you, our office verifies benefit information prior to your visit whenever possible and we do our best to inform you of these benefits. However, be aware the insurance company states that “the quote of benefits is not a guarantee of payment.” Therefore, we cannot be held responsible for any misinformation we are given by your insurance.
It is ultimately your responsibility to know your own benefits and to pay the balances as indicated by your insurance company.
5. **Insurance Claim Filing and Payment**
 - a. **Our office files your insurance claims as a courtesy, however, if payment from an insurance company is withheld for any reason (i.e., if it’s denied, suspended or pended for additional information from the insured/dependent) payment in full will be expected from the insured within 21 days of the first statement and/ or 45 days of the service date.**
 - b. **Assignment is Accepted on Medicare Part B Claims.**
This means that Medicare participants are responsible for:
 - Your \$200.00 deductible.
 - The balance of the 20% co-insurance after Medicare pays 80% of their allowed amount.
 - Any non-covered services (we are required to submit all claims to Medicare whether they are paid or not by the patient at the time the services are rendered.)
6. **Account Balances**
 - a. **Payment of co-payments, previously determined non-covered services or services rendered to a non-insured patient are expected at the time services are rendered.**
 - b. **Payments may be made to our office with a valid Visa, MasterCard, American Express, Discover card, Money Order, Cashier’s Check, Cash or a local check with a current Illinois Driver’s license or State Identification Card.**
Any payment made by a credit card in full will receive a \$5 credit card discount per statement.
A fee of \$25.00 will be assessed for any returned checks.
 - c. **Payment plans are available with a valid Visa, MasterCard, American Express or Discover Card. If you do not have a credit card, post dated checks are accepted to be deposited monthly until bill paid.**
 - d. **For those patients with deductibles of \$300 or more per the insurance company:**
 - We will require a payment plan with a credit card. If the bill is not paid within 30 days of the first statement, the amount will be billed to the credit card.
 - If you do not have a credit card, a deposit of 50% of the total bill for that day will be assessed and will be due each visit until the deductible has been satisfied.
 - e. **Statements are generally mailed from our office on a monthly basis and payment is expected upon receipt.**
 - f. **Your account will be considered PAST DUE after 21 days of the first statement and/or 45 days of the service date and DELINQUENT after 60 days. Failure respond to your statements will result in the account being sent to a collection agency and/or an attorney for collection which will make**

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you responsible for all attorney fees, court and collection fees in association with the unpaid balance and may also damage your personal credit rating.

g. Extenuating circumstances should be brought to our attention immediately to avoid collection proceedings.

7. Medical Records and/or X-ray copies

- a. Copies of medical records and x-rays are provided for a fee to cover cost of materials and staff time to prepare (based on current fees according to Illinois State Comptroller's office). Copies take a minimum of 48 to 72 hours to prepare and could take up to a minimum of 3 weeks.**
- b. X-ray copies: \$10 for the first plate and \$5 for each additional plate**
- c. Medical Records copies: \$23.78 handling fee plus 0.89 cents each for pages 1-25, 0.59 cents each for pages 26-50, and 0.30 cents each for pages 51 to end.**

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 IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** is providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a consultation or physical examination.
- **Payment** is such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects such as an internal review.

We may contact you to provide appointment reminders, information about treatment alternatives or results of tests taken.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person

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identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or locations. An example such as a different mailing address for statements or a different telephone number for communication.
- The right to inspect and copy your protected health information. The practice charges reasonable fees based on Illinois laws. If the requestor agrees to pay the fee in advance, the records will be provided. Otherwise, the records will not be provided, unless the Privacy Officer determines that the charge is burdensome to the requestor. The charges cannot exceed the following: \$23.78 handling fee plus 0.89 cents each for pages 1-25, 0.59 cents each for pages 26-50, and 0.30 cents each for pages 51 to end.
- The right to amend your protected health information. The practice documents all requests, responds to the requests in a timely fashion, and informs requestor of denial in whole or in part.
- The right to receive an accounting of disclosures of protected health information. The practice allows an individual to request one accounting within a 12-month period free of charge. The practice charges a reasonable fee for more frequent account requests. The charge will be determined at the time of the request.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

The practice never requires an individual to waive any of his or her individual rights as a condition for the provision of treatment, except under very limited circumstances allowed under law.

You have the right to file a written complaint with our office, Attn: Privacy Officer, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Privacy Officer: Ricardo Montano

Contact Name: Ricardo Montano

Phone Number: (630) 530-5757

Fax: (630) 203-1640

E-mail: rmontano@anklenfoot.com

Address: 401 N. York Rd.
Elmhurst, IL 60126