Ankle N Foot Centers, LLC

Dr. George Tsatsos. • Dr. Kevin Massard • Dr. Rachel Glick • Dr. Gagandeep Sandhu 401 N. York Rd., **Elmhurst**, IL 60126 (630) 530-5757 • 321 Railroad Ave, **Bartlett,** IL 60103 (630) 213-3830
2220 W. Belmont Ave., **Chicago**, IL 60618 (773) 348-7500 •
225 S. Jefferson St, **Chicago**, IL 60661 (312) 612-5000 • Fax: Same as phones per location

PATIENT INFORMATION: Chart#: _____

First: _____M. _____**Last**:_____

Sex: Male ___ Female___ **Date of Birth**:_____ **Social Security** #: _____

Marital Status: Married ___ Single ___ Widowed ___ Divorced ___ Separated ___ Minor ___

Race: White____ Black or African American____ American Indian____ Asian____ Hispanic or Latino____ Hawaiian_____

Other_____ **Language:** English____ Specify Other_____

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

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

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

Emergency Contact: Name_____ **Phone** _____

Employer Name: _____ **Employer Tel#**:_____**Occupation**:_____

Please indicate in order of preference how you would like to be contacted or messaged:
Home Phone_____ Cell Phone_____ Email_____
Please initial: _____

Pharmacy:_____ Pharmacy Phone:_____ Pharmacy Address:_____

INSURANCE INFORMATION:

Self Pay: _____ Workman's Comp related? Y ___ N ___

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

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

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

Secondary Insurance Name: _____**Phone#** _____

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

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

Referral Source:
Please help us continue to provide the best conservative and surgical podiatric care in the Chicago-land area.

1. **How did you hear about us?** (Check all that apply)

□ Google	□ Facebook	□ Patient Referral (please specify) _____
□ ZocDoc	□ Amazon	□ Doctor Referral (please specify) _____
□ Living Social	□ Groupon	□ Mailer / Magazine (please specify) _____
□ Yelp!	□ Insurance Website	□ Other (please specify) _____

2. **List the key words used to find us (i.e. Foot Pain, Podiatrists (zip or other), Nail Fungus, etc). _____**

3. **How did you schedule your appointment?** (Check all that apply)

□ Email □ Phone □ Walk-In □ Anklenfoot.com Website □ Online Scheduler

Please look us up on YELP! We appreciate your feedback & reviews!
Also, don't forget to "like" us on Facebook.

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

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PATIENT NAME: _____ Chart#:_____

MEDICAL INFORMATION/ HISTORY:

1. **Foot/Ankle Complaint**: _____ **Date of symptoms**: _____
2. **Accident Related?** No___ Yes (please specify)_____
3. **Rate your Health**: Excellent ___ Good ___ Fair ___ Poor ___ **Height** _____ **Weight**_____ **Shoe Size** _____
4. Do / have you ever worn **custom foot orthotics**? Yes____ No____
5. **Primary Care Physician Name**: _____ **Phone**_____

   Date Last Seen: _____ Reason_____
6. Are you now, or have you been under **a physician or specialist care** during the **past two years**? Yes___ No ___

   Reason / Condition (s)?_____
7. List **all** serious illnesses, injuries or surgeries (include dates):

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

   _____
9. **Do you have any allergies?** Novocaine ___ Codeine ___ Penicillin ___ Other Medications / Foods _____

   No Known Allergies: ___ _____
10. Are you subject to **prolonged bleeding**? Yes ____No ____
11. Are you now or have you ever been a **smoker?** Yes ____ No ____Amount: _____ Quit? How Long Ago_____
13. Do you consume **Alcohol?** Yes____ No____ Amount: _____ Quit? How Long Ago_____
14. Have you **fallen in the past year**? Yes ___No ___ Has it resulted in an **injury**? Yes ____No _____
15. Do you **or** a blood relative have a **history of any of the following**?

	Self	Family (who)	N/A		Self	Family (who)	N/A
Heart Conditions	☐	☐ _____	☐	Hypertension	☐	☐ _____	☐
Diabetes	☐	☐ _____	☐	Anemia	☐	☐ _____	☐
Liver Problems	☐	☐ _____	☐	Arthritis	☐	☐ _____	☐
Kidney Problems	☐	☐ _____	☐	Gout	☐	☐ _____	☐
Cancer	☐	☐ _____	☐	Epilepsy	☐	☐ _____	☐
Vertigo	☐	☐ _____	☐	Fainting	☐	☐ _____	☐
Asthma	☐	☐ _____	☐	Other	☐	☐ _____	☐

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

- ☐ I give permission to Ankle N Foot Centers 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 authorize ankle & foot center representatives to speak to other doctors or representatives to obtain any information needed for my treatment or processing of claims.
- ☐ By signing below I hereby authorize the release of medical records necessary for this review. I understand that these records may be obtained from the insurance carrier, the utilization review company, and/or any relevant medical provider(s) and will be utilized solely for the purpose of conducting this review and may be viewed by an auditor of the Department of Insurance for quality review and examination of record purposes.

_____ _____

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Thank you for choosing our office to serve your podiatric needs. We welcome you and hope that you will be satisfied with our services.

Office & Financial Policies

1. **Please give 24 hours notice of appointment cancellation.**
   If you fail to give notice, we will charge your account a **$35 missed appointment fee**. For surgeries, a $375 deposit is due - if you fail to give **Five Days cancellation notice**, a **$375 fee applies**. **Deposit is due even if deductible is met.**

2. **Kindly inform our office staff of any changes in your personal or medical information** including but not limited to: Address, telephone number, insurance information, medications, allergies, and symptoms.

3. **Our office requires:**
   a. **Copy of your insurance card (s)**
   b. **Photo ID**
   c. **A Credit Card to keep on file for co-pays and past 45 days from date of service balances.**

4. **Know your own Insurance Plan Benefits**
   a. When possible, and as **a courtesy to you**, our office verifies basic benefit information prior to your visit whenever possible
   b. Be aware the insurance company states that **"the quote of benefits is not a guarantee of payment."**
   c. **We cannot be held responsible** for any misinformation we are given by your insurance.
   d. **Treatments provided are medically necessary and payment is your responsibility.**
   e. **It is ultimately your responsibility to know your own benefits and to pay balances as due.**

5. **Insurance Claim Filing and Payment**
   a. **Our office files your insurance claims as a courtesy**.
   b. If payment from an insurance company is withheld for **any reason**, payment in full will be expected from the insured within **21 days of the first statement and/ or 45 days of the service date**.
   c. **Assignment is Accepted on Medicare Part B Claims**.
      This means that **Medicare participants are responsible** for:
      - **Your $183.00 deductible**.
      - The balance of the **20% co-insurance after Medicare** pays 80% of their allowed amount.
      - Any non-covered services not covered by Medicare. (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.) You will be notified of non-covered services prior to treatment.

6. **Account Balances**
   a. **Co-payments, previously determined non-covered services or services rendered to a non-insured patient are expected at the time services are rendered**.
   b. **Deductibles of $250 or more**, a minimum of **$250** down **payment** is required towards your **balance, Deductibles of $500 or more**, a minimum of **$350** down **payment** is required towards your **balance** & arrangements must be made to pay the balance within 45 days from date of service.
   c. We accept Visa, MasterCard, American Express, Discover Card, Money Order, Cashier's Check, Healthcare Savings Card, Cash or a local check
   d. **A fee of $45.00 will be assessed for any returned checks.**
   e. Statements are mailed from our office every 21 days and payment is expected upon receipt. Account balances that are **45 days past due** from the date of service will have credit cards on file automatically **charged.**
   f. **If no payment is received after 60 days from date of service, and statements are not paid, the account will be forwarded to our collection agency**.
   g. **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 you responsible for all attorney fees, court and collection fees in association with the unpaid balance and may also damage your personal credit rating. If your account is forwarded to a collection agency, a fee of 30% of your total balance will be added to your bill.**

7. **Medical Records and/or X-ray copies**
   a. Copies take a minimum of 72 hours to prepare and could take up to a maximum of 2 weeks.
   b. Medical Records copies: $26.77 handling fee plus $1 each for pages 1-25, 0.67 cents each for pages 26-50, and 0.33 cents each for pages 51 to end.

_____ _____

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