FOOT AND ANKLE SPECIALISTS

24039 W. Lockport St Plainfield, IL 60544
9S157 Route 59, Naperville, IL 60564
1851 S Douglas Rd, Montgomery, IL 60538

"with you at every step"

PATIENT REGISTRATION

NAME _____
LAST FIRST MI

DOB _____ AGE _____GENDER ___MALE ____FEMALE_____

ADDRESS _____

CITY/STATE _____ZIP _____

PHONE NUMBER(**HOME**) _____(WORK)_____

(**CELL**) _____CELLPHONE CARRIER_____

SOCIAL SECURITY _____MARITAL STATUS _____

PREFERED LANGUAGE: _____

EMPLOYER _____ CITY/STATE _____

OCCUPATION_____

EMAIL _____

BEST FORM OF CONTACT _____HOME _____CELL_____EMAIL_____MAIL

PRIMARY INSURANCE

____SAME AS INSURANCE CARD COPY

INSURANCE COMPANY_____

CARD HOLDER _____ RELATIONSHIP _____

ID # _____ GROUP _____PHONE _____

Do you have secondary insurance? _____Yes _____No

SECONDARY INSURANCE

____ SAME AS INSURANCE CARD COPY

INSURANCE COMPANY_____

CARD HOLDER _____ RELATIONSHIP _____

ID # _____ GROUP _____PHONE _____

NAME OF PERSON RESPONSIBLE FOR PAYMENT _____

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EMERGENCY CONTACT/RELATIONSHIP_____

PHONE _____

WHOM MAY WE THANK FOR REFERING YOU?

DOCTOR _____ PATIENT_____

OTHER (PLEASE BE SPECIFIC) _____

INFORMATION & ASSIGNMENT OF BENEFITS

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I PERMIT A COPY OF THIS AURHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.
I HEREBY AUTHORIZE DR. PRAVEEN VOHRA / DR. RICHA VOHRA TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED BY HIM/HER, OR BY HIS/HER ORDER. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO DR. PRAVEEN VOHRA / DR. RICHA VOHRA. I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT.I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THIS AUTHORIZATION MAY BE REVOKED BY EITHER ME OR MY INSURANCE COMPANY AT ANY TIME IN WRITING.

DATE _____ SIGNATURE _____

GENERAL MEDICAL INFORMATION

IF ACCIDENT, WAS IT REALATED TO WORK _____AUTO_____OR OTHER_____

LIST DATE OF INJURY_____

GIVE A BRIEF DESCRIPTION OF HOW IT HAPPENED:

_____

_____

DESCRIBE THE REASON FOR TODAY'S VISIT

_____

_____

_____

HOW LONG HAS IT BEEN BOTHERING YOU _____DAYS _____ WEEKS _____YEAR

ANY PAST PROBLEMS WITH YOUR FEET OR ANKLES _____

_____

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PREVIOUS SURGERIES OF YOUR FEET/ANKLES INCLUDE TREATING PHYSICIAN_____

_____

WEIGHT _____HEIGHT _____ SHOE SIZE _____

FAMILY PHYSICIAN _____LAST SEEN _____

OTHER SPECIALIST:_____LAST SEEN:_____

OTHER SPECIALIST:_____LAST SEEN:_____

CAN WE CONTACT PHYSICIANS ABOUT YOUR HEALTH _____ YES _____NO

PHARMACY NAME _____ NUMBER _____

ARE YOU UNDER A PHYSICIANS CARE/ WHAT CONDITIONS _____

ARE YOU A DIABETIC? NO____IF YES DO YOU TAKE INSULIN? YES__ NO__

HOW LONG HAVE YOU BEEN A DIABETIC?

_____

MEDICATIONS YOU TAKE REGULARLY _____

_____

HOW YOU HAD ANY SERIOUS ILLNESSES _____

HAVE YOU HAD ANY MAJOR SURGERIES _____

_____

ARE YOU **ALLERGIC** TO ANY OF THE FOLLOWING

ANTIBOTICS _____

MEDICATIONS _____

TAPE/ADHESIVES _____

BETADINE/IODINE _____

ASPRIN / IBUPROFEN _____

NOVOCAINE / LIDOCAINE _____

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DO YOU CURRENTLY, OR IN THE PAST, HAVE PROBLEMS WITH ANY OF THE FOLLOWING:
(PLEASE CIRCLE)

FREQUENT INFECTIONS	SKIN	HEART	KIDNEYS
STOMACH ULCERS	TUBERCULOSIS	ASTHMA	GOUT
NEUROLOGICAL DISORDERS	RHEUMATIC FEVER	HEALING	BLADDER
LUNGS	LIVER	ANEMIA	ARTHRITIS
INTESTINES	CIRCULATION	HORMONES	CANCER
BLOOD PRESSURE	UNEXPLAINED WEIGHT LOSS/GAIN		HEPATITIS
DIABETES MELLITUS	STROKE	OTHER:_____	

DO YOU HAVE ANY ARTIFICIAL JOINTS YES ____NO____
_____HIPS _____ KNEE _____OTHER

DO YOU HAVE VALVE IMPLANT YES_____NO ___

FAMILY HISTORY

IS THERE A FAMILY (BLOOD RELATIVE) HISTORY OF:

	RELATION (FATHER/MOTHER)		RELATION
HEART DISEASE	_____	STROKE	_____
ARTHRITIS	_____	BUNIONS	_____
BLEEDING DISORDER	_____	FLAT FEET	_____
NEUROLOGICAL DISORDER	_____	HAMMEROTES	_____
CIRCULATION PROBLEMS	_____	CANCER	_____

DO YOU SMOKE NO ___YES, HOW MUCH_____HOW LONG
_____

DID YOU SMOKE PREVIOUSLY? NO ____YES, # OF YEARS _____

DRINK BEER/ALCOHOL _____ LIGHT/SOCIAL _____ MODERATE _____ HEAVY _____

DOES YOUR JOB REQUIRE YOU TO: _____ SIT / (MOSTLY AT A DESK) _____ STAND

_____STAND & WALK _____ RETIRED _____UNEMPLOYED/STUDENT

SIGNATURE _____DATE_____

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ARE YOU SUFFERING FROM ANY PROBLEM LISTED BELOW?(PLEASE CIRCLE ALL THAT APPLY)

HEAD:	Chronic Headaches, Concussions, Dizziness, Loss of Consciousness
EYES:	Glasses, Contacts, Double Vision, Blurred Vision, Blindness, Glaucoma, Cataracts
EARS:	Decrease or loss hearing, Tinnitus, Chronic Earaches, Drainage or Infections
THROAT:	Chronic tonsillitis, Laryngitis, Dysphasia, Loss of Speech, Thyroid disorder
NOSE:	Chronic Drainage, Blockage, Epistaxis, Sinusitis
CVS:	Heart Attack, High Blood Pressure, Rheumatic Fever, Chest Pain, Shortness of Breath, Fluttering heart beats, heart murmur, valvular disease, anemia
RESPIRATORY:	Asthma, Difficulty night breathing, TB, Pleurisy, Emphysema, Pneumonia
G.I:	Peptic or Duodenal Ulcer, Chronic Nausea, Vomiting, Diarrhea, Constipation, Weight Gain or loss, jaundice, hepatitis, gall bladder disease, gallstone, blood in stool, hematemesis, colitis, diverticulitis, polyps, appetite disorders
G.U:	Chronic kidney or bladder infections or stones, dysuria, pyuria, hematuria, venereal disease
GYN:	Dysmenorrhea, amenorrhea
MUSK:	Gout, Rheumatoid Arthritis, Trauma, Fracture, Dislocations

CONSENT FOR TREATMENT:
To the best of my knowledge, the information given is correct. I hereby give my permission to Foot And Ankle Specialists to administer treatment and to perform such procedures as deemed necessary in the diagnosis and/or treatment of my foot condition.

Signature of Patient
(Guardian if Patient is a minor)

X_____Date:_____

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Please thoroughly read each **FOOT AND ANKLE SPECIALISTS** policy, initial next to policy and sign below:

Initial **TREATMEANT AGREEMENT**

____ I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy and/or medications, the outcome of my care and treatment could be put into jeopardy and less than optical results may occur.

PATIENT FINANCIAL POLICY

____ You must provide personal and/or insurance changes to the office at least 2 days ***prior*** to your appointment. In the event the office is not informed, you will be responsible for any charges denied.

____ You are responsible for all authorizations/referrals/precerts needed to seek treatment with **Foot and Ankle Specialists** physicians. If you are unsure if your referral or precert is current please check with one of our representatives.

____ Your portion of payment for ALL services is **due at the time of service.** We will accept VISA, MasterCard, cash or check. All benefit quotes or price given are merely an estimate and are not a guarantee and are subject to change, based on your insurance carriers determination, there may be an additional balance due.

____ Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you with an assignment of benefits. You are agreeing to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, the patient or guardian seeking care for a minor, will be responsible for payment of services. You are encouraged to contact your designated patient account representative at our office with questions.

____ Please honor our 24 reschedule notice, as there may be a charge for your appointment broken or cancelled without 24 hour advance notice. Repetitive broken or cancelled appointment and/or non-compliance may result in transferred of your care to an alternative practice.

____ We have made prior arrangements with insurers and other health plans to accept and assignment of benefits. We will bill those plans with we have an agreement and will **require you to pay the co-pay/co-insurance/ deductible at the time of service.** Your upfront portion will be calculated based on your insurance benefit/limit and our negotiated fee agreement with your carrier. If you are seeing our doctors on an "OUT OF NETWORK" basis, you will be subjected t our out of network rates. Once the claims are processed by your insurance there may be an additional balance we will bill you for this amount.

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_____ Not all services are a "covered" benefit in all insurance policies; some plans even impose a waiting period before covering services. In the even your health plan determines a service to be "not covered/pre-existing" or you do not have an authorization, you will be responsible for all charges to any service rendered, **PATIENTS ARE ENCORAGED TO CONTACT THEIR PLAN FOR CLARIFICATION OF BENEFITS PRIOR TO SERVICE RENDERED.**

_____ Our office does not file tertiary insurance. For all other insurances, we will provide an itemized statement upon your request. If you possess two insurances, you **MUST** notify us of your designated **PRIMARY** policy.

____ Pre-scheduled surgical procedures require pre-payment/estimate deposit. Your deductible/co-insurance/co-pay for this procedure is due at the pre-operative appointment. For other services provide in the hospital, we will bill your health plan. Any balance due is your responsibility.

_____ We realize that temporary financial problems may affect timely payment of our account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Any payment exceptions will be agreed upon in writing. We are happy to discuss repayment options.

____ PAST DUE account are subjected to collection proceeding including the credit bureau. I acknowledge that any balance 30 days past due may be subject to a 1.5% monthly service charge (cumulative per annum) until the account is paid in full, or satisfactory payment arrangements have been mutually agreed to. I agree to pay for all costs and expenses, including reasonable court and attorney fees, should they become necessary to collect unpaid balances.

____ Accounts no longer maintaining a financial "Good Faith" status will result in the termination of the Foot And Ankle Specialists Doctor-Patient relationships.

____ There is a service fee of $40.00 for all returned check. Upon an NSF or CLOSED ACCOUNT occurrence, all future remittances will need to be in other form of payment. Restitution of "Theft-by-Check" will be requested from the District Attorney's Office.

____ Medical records are the property of the office. We can make arrangements for you to get a copy with 30 days notice.

____ Disability forms or work that need to be completed by our office will incur a charge of $10.00 per form occurrence.

____ Minor Patients if unaccompanied non-emergency treatment will be denied unless appropriate consent has been received and charged have been pre-authorized.

All Patients

Responsible Party Signature _____ **Date** _____

Medicare Authorization

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I request that payment of authorized Medicare benefits be made on my behalf to Dr Vohra for any services furnished to me by said physician. I also authorize any holder of my private health information to release to the health care financing / administration and its agents and information needed to determine benefits payable for related services. I understand that my signature represents that payment be made and authorizes release of medical information to pay the claim. I understand that any health insurance listed on the HCFA form or electronically submitted claims indicating their coverage, my signature also authorizes release of information to insurer or agency shown. In Medicate assigned cases, the Physician or supplier agrees to accept the charge determination that Medicare assigns and that the patient is responsible for only the deductible, co-insurance, and non-covered services.

Beneficiary Signature _____ **Date** _____

Auto and Personal Injury / Accidents- Notice to Lien Attorney

I hereby authorize and direct you, my attorney to pay directly to my doctor any such sums as may be due and owing to him for medical services rendered to me as a direct or indirect result of this accident and by reason of any other bills that are due this office, and to withhold such sums from any settlement, judgment or verdict as may be necessary to protect said doctor. I further give a lien to my case to said doctor against any and all said settlement judgment or verdict which may come payable to you my attorney, or myself as a result of the injuries for which I have been treated, or injuries in connection therewith. I acknowledge that any balance 30 days past due may be subject to a 1.5% monthly service charge (cumulative per annum) until the account is paid in full, or satisfactory payment arrangements have been mutually agreed to. I agree to pay for all costs and expenses, including reasonable court and attorney fees, should they become necessary to collect unpaid balances.

I agree to never rescind this document, and that a rescission will not be honored by my attorney. I hereby instruct that in the event that any other attorney is substituted or hired to represent me in this matter, the new attorney will honor this lien as inherent to the settlement and enforceable upon the case as if said attorney executed it. A copy of this document shall be provided upon request.

Patients Signature _____ **Date** _____