TRI-COUNTY FOOT & ANKLE CENTERS; LTD
4310-F Crystal lake Rd. McHenry, IL 60050 Iqbal Khan DPM Tel: (815) 363-3223 Fax: (815) 363-3240

REGISTRATION

Date ___________________ Home Phone _______________________ Cell Phone ____________________ Email _____________________
Patient Last Name ______________________________ First Name _________________________________ Initial _____________________
Street Address ____
City ____ State _____________________________ Zip _____________________
Sex □ M □ F Age ______ Birth date ____________ □ Single □ Married □ Widowed □ Separated □ divorced
Social Security # ____ Driver's License # ____
Insured Name ___________________________Insured's Birth date ____________How and where did you learn about this clinic? ___________
Last Name First Name In
Relationship to Insured □ Self □ Spouse □ Child □ Other
Condition/Illness Related To □ Illness □ Employment □ Auto □ Other

EMPLOYER	Company Name ____ Occupation _______________________ Address ____________________________________ Phone _________________ □ Full-time □ Part-time City ______________________________ State _______________ Zip __________ Years Employed __________
SPOUSE (PARENT)	Name ____ Birth date ______________ SSN: __________________ Last Name First Name Initial Employer Name ____ Years Employed __________ Address ______________________________________ Phone ______________ Occupation _________________ City _____________________________ State ___________________ Zip ____________ □ Full-time □ Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name ____ Policy/Group #: ____ Effective Date: ______________________ Name of Insured: ____ ID #: __________________________
SPOUSE COINSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plane Name ____ Policy/Group #: ____ Effective Date: __________________ Name of Insured: ____ ID #: ______________________

MEDICAL AND LEGAL INFORMATION	**Are you present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for?** □ Yes □ No Your Initials: ____________________ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant □ Yes □ No Pacemaker □ Yes □ No Family Physician ______________________________ Person to contact in emergency (Name and Phone #) ____ Attorney ____ Telephone: ___________________________ Address: ____
PATIENT AGREEMENT	**LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Tri-County Foot & Ankle Centers; LTD. All medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/ or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medial benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against such insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti assignment is waived. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. ____ ____________________________ Signature of Insured/Guardian Date

MEDICAL INFORMATION

This Information Is Important For Our Records and Your Health

Describe your foot problem:				
How long has it been bothering you?	□ Days	□ Weeks	□ Months	□ Years
Any past problems of your feet and ankles?				
Any past surgical procedures on your feet or ankles?				
Shoe size	Current Weight	Height		
Are you allergic or sensitive to?				
□ Antibiotics (Penicillin, Sulfa drugs, etc.?)				
□ Any Medicines Allergies?				
□ Tape?	□ Betadine (Iodine)?			
□ Other?				
Have you had problems taking aspirin or ibuprofen (Advil, Motrin)?	□ yes	□ No		
Any problems with local anesthetics (Novocaine, Lidocaine)?	□ Yes	□ No		

GENERAL HEALTH INFORMATION			
Do you have diabetes?	□ Yes □ No	If yes, do you take insulin? □ Yes □ No	Number of years?
Have you had any serious illnesses?	□ Yes □ No	If yes, for what conditions?	
Have you had any major surgeries?	□ Yes □ No	If yes, for what conditions?	
Are you under a physician's care?	□ Yes □ No	If yes, for what conditions?	
Physicians name	Date you last saw this Doctor:		
May we contact your physician about your health?	□ Yes □ No		
What medications do you take regularly?			

Check any of the following you have, or have had problems with:

□ Heart	□ Asthma or Breathing Difficulty	□ Skin	□ Unexplained fever
□ Circulation	□ Stomach Ulcers	□ Gout	□ Unexplained Weight Loss
□ Arthritis	□ Hormones	□ Tuberculosis	□ Frequent Infections
□ Kidneys or Bladder	□ Anemia	□ Rheumatic Fever	□ Healing
□ Lungs	□ Bladder	□ Liver	□ Neurological Disorder
□ Cancers	□ High Blood Pressure	□ Eye, Ear, Nose, or Throat	□ Intestines

Do you have any artificial joints?

Hip □ Yes □ No Right / Left
Knee □ Yes □ No Right / Left
Other ________________________

Do you have Heart Valve Implant? □ Yes □ No
Do you have a Mitral Valve Prolapse? □ Yes □ No

Family History:

Mother:	□ Living	□ Deceased	Cause of Death________________________
Father:	□ Living	□ Deceased	Cause of Death________________________
Brother:	□ Living	□ Deceased	Cause of Death________________________
Sister:	□ Living	□ Deceased	Cause of Death________________________

Is there a family (blood relative) history of:

□ Heart Disease	□ Bunions
□ Arthritis	□ Hammertoes
□ Bleeding Disorder	□ Flatfeet
□ Neurological Disorder	□ Circulation problems in leg or feet?
□ Stroke	□ Diabetes

Do you smoke? □ Yes # packs per day? _______ □ No

Previously Smoked? □ Yes # of years? _______ □ No

Do you drink alcohol or beer? □ Yes □ No

□ Light usage 1-2 per week □ Moderate 1-2 per day □ Heavy more than 2 daily

Recreational drug use? □ Yes □ No

Employment: □ Sit at job □ Stand at job □ Stand & walk at job □ Retired

Signature: ________________________________ ***Date***: ________________________

Patient Financial Policy

We are dedicated to providing the best possible care and service to you and regard your complete understanding our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept cash or check.

- Your insurance policy is a contract between you and your insurance. As a courtesy, we will file your primary insurance claim for you if you assign the benefits to the doctor, **however** we do not file secondary insurance claims. In other words, you pay the practice within a reasonable period; we will have to look to you for payment.

- We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.

- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

- You must inform the office of all-insurance charges and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain electives surgical procedures that we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: ______________________________________

Witness: ____________________________________ Date: _______________________

________ Patient initials to indicate copy received.

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding
the attached Notice of Privacy Practice

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Use and Disclosures of/ Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Use and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization.

- To family members or close friends who are involved in your health care;
- For certain limited research purposes:
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects of incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To receive notice of your privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

____ ______________________
Patient Name (please print) Date

____
Parent or Authorized Representative (if applicable)

____
Signature