Laura J. Pickard DPM, PC
Norridge Foot Clinic
7325 W. Irving Park Rd.
Chicago, IL 60634

PATIENT INFORMATION

Name________________________________ Date of Birth ______________ Age:______

Address________________________________ City______________ State________ Zip__________

S. S. #__________-_______-____________ Gender: ☐ MALE ☐ FEMALE

Phone: Home (   ) ________________ Work (   ) ________________ Cell ( ) ________________

E-Mail________________________ Employer________________________________

How did you find out about our office?________________________________

EMERGENCY CONTACT

Name: ________________________________ Relationship________________________

Phone: Home (   ) ______________ Work (   ) ____________ Cell ( )____________

MEDICAL INSURANCE

Primary Insurance:	Employer:
I. D #:	Address:
Group #:	City & Zip:
Secondary Insurance:	Verification of Benefits#
I.D. #:	
Group #:	
Spouse's Name or if minor, Parent or Guardian:	
Spouse's Soc. Sec. # __________-_______-____________	Date of Birth:

CHIEF FOOT COMPLAINT? ________________________________

I HEREBY GIVE PERMISSION TO DR. LAURA J. PICKARD DPM, PC. OR STAFF TO ADMINISTER TREATMENT AND PERFORM SUCH GENERAL PROCEDURES AS MAY BE NECESSSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FOOT CONDITION. THIS MAY INCLUDE THOSE DIAGNOSTIC TESTS AND TREATEMENTS GENERALY PERFORMED BY PODIATRISTS IN THE CARE OF SIMILAR CONDITIONS.

DATE: ______________________ SIGNATURE:________________________________

PLEASE READ FINACIAL ARRANGEMENTS ON REVERSE SIDE BEFORE SIGNING

History & Medical Information

1. Primary Care Physician: ______________________
   Phone Number: ( ) __________ Date of last visit: __________
2. Height: ______ Weight: ________
3. Explain your foot/ankle problem: ______________________
4. When did pain/discomfort begin? (date): ______________________
   Describe pain: discomfort: Burning Numbness Sharp other: __________
5. What makes pain/discomfort better?: ______________________

6. What makes pain/discomfort worse?: ______________________

7. Has condition been treated?: YES NO When and how: ______________________

8. Past Medical History:

☐ Anemia	☐ Gout	☐ Kidney Disease	☐ Other Arthritis
☐ Bleeding Disorders	☐ Heart Disease	☐ Lung Disorders	☐ Prostate Disorders
☐ Cancer	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Rheumatic Fever
☐ Diabetes	☐ High Cholesterol	☐ Nerve Disorders	☐ Thyroid Disorders
☐ Epilepsy	☐ HIV/ Aids	☐ Neurologic	☐ Stroke
	☐ High Blood Pressure	☐ Osteoarthritis	☐ Other: ________

9. List all Medications/herbs/vitamins: ☐ None

____

____

What is you Pharmacy name? ______________________ Phone # __________

10. Allergies: ☐ None

☐ Penicilin	☐ Aspirin	☐ Shellfish
☐ Narcotic Agent/ Codeine	☐ Anesthesia	☐ Other __________
☐ Sulfa Drugs	☐ Radiographic Contrast/ Dyes	

10. Surgical History:
Have you had Surgery: ☐ YES ☐ NO
Describe:(surgery/date): ______________________

____

11. Social History:

☐ Tobacco Use* ☐ Alcohol use ☐ Exercise Habits __________ *If Yes How Much?* __________
☐ Caffeine Use ☐ Drug Use (recreational,IV) ☐ Pregnant ☐ Nursing

12. Occupation/Job: ______________________

13. Family history: (list relationship of member(s) who have had problems)

☐ Diabetes	☐ Heart Disease	☐ Bleeding Disorders	☐ Mental Illness
☐ High Blood Pressure	☐ Stroke	☐ Kidney Disease	☐ Cancer
☐ Rheumatology	☐ Other Family History: __________		

ABOUT FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you with the best possible foot care. If you have medical insurance, as a courtesy we may check benefits, (which is not a guarantee of payment) and pursue your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however, that:

1. Your insurance is a contract between you, your employer and/or the insurance company. We are not a party to that contract unless you are covered by a PPO plan in which we are a member. As a PPO provider, we honor contractual adjustments in accordance with the insurance fee schedule. The patient portion is due in full within 30 days of any and all periodic and/or final payment or adjudication. Any PPO unpaid insurance claim(s) over 30 days will be non-compliant with the PPO contract and will in turn become your responsibility in full. This is policy in accordance with the Prompt Payment Pay Law, (P.A. 91-605).
2. Our fees are within federal and state acceptable ranges, and therefore are covered up to the maximum allowance determined by indemnity carriers. This applies only to companies who pay a percentage (such as 80%) of the usual, customary and reasonable fees for this area. Thus our fees are considered usual and customary by most companies. This does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of medical care in this area. Any balance unpaid by an indemnity plan, will be due from the patient. All balances after insurance are due in full within 30 days of an insurance period and/or final payment or adjudication.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. You need to be aware of your policy limitations. If this should occur, the non-covered service will become a patient portion.

We must emphasize that as foot care providers, **our relationship is with you,** <u>not your insurance</u> company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If not further action will be taken. Returned checks are subject to a $25.00 fee.

<u>ATTN: MEDICARE PATIENTS</u>...As assignment doctors, we have agreed to accept the **MEDICARE ALLOWABLE AMOUNT** in full payment for all "covered" services. Once you have paid for the first $100 in "covered" services or your deductible has been filled, we request that the 20% coinsurance portion be paid at the time services are rendered. **WE WILL FILE ALL INSURANCE FOR YOU SO THAT YOU WILL BE REIMBURSED BY YOUR COINSURANCE. DUE TO THE DIFFERENT TYPES OF POLICIES WE CANNOT GUARANTEE YOUR REIMBURSEMENT.**

I understand that I (or other responsible party listed below) am responsible for payment of the medical and surgical charges provided by LAURA J PICKARD DPM PC that are not covered under the terms of my insurance plan. Further, unless prohibited by the assignment terms of my plan, should no payment be received from my plan on or before 60 days from the date my claim is filed, I will make reasonable and timely monthly payments on my charges, each payment being no less than 20% of the original balance due.

I authorize the release of any medical or other information necessary to process my medical claims. I also authorize the assignment of benefit payment directly to LAURA J PICKARD DPM PC.

If you have any questions about the above information or any uncertainty regarding insurance coverage, **PLEASE** don't hesitate t ask us. We are here to help you.

I have read the above financial policy and fully understand my responsibilities.

Date ______ Patient (signed) ______

______
Date Signature of Responsible Party

______
Print Name of Responsible Party

______
Relationship to Patient

Rev 021507