New Patient Intake Form

Name: _____
Last, Name, First Name

First Appointment Date:_____
PATIENT:
Address: _____

City: _____

State: _____ Zip: _____

Email: _____

Primary Phone: (_____) _____

Alt. Phone: (_____) _____
Circle one - cell phone, work phone, spouse phone

Sex: ☐ Male ☐ Female Birthdate: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced

☐ Widowed ☐ Separated

Preferred Language: ☐ English ☐ Spanish

Other: _____

Race: ☐ White ☐ Black/African American ☐ Asian

☐ American Indian/Alaska Native ☐ Pacific Islander

Ethnicity: Hispanic or Latino ☐ Yes ☐ No

Preferred method for our office to communicate with you:

☐ Telephone ☐ email

GUARDIAN/LEGAL REPRESENTATIVE

If you not financially responsible for payment for your services, please write the information for the responsible party below.

Name: _____

Address: _____
(Write "Same" if you live with the guardian/legal representative)

City: _____

State: _____ Zip: _____

Email: _____

Primary Phone: (_____) _____

Are you a student?

☐ No ☐ Full-time student ☐ Part-time student

INSURANCE:

Please provide us with your drivers license/state ID and all current insurance cards upon arriving for your visit.

Primary Insurance:_____

Primary Insurance ID #: _____

Primary Insurance Group #: _____

Are you the subscriber or dependent of subscriber?

☐ Subscriber ☐ Dependent

If Dependent, please write the subscriber information.

Name: _____

Address: _____
(Write "Same" if you live with the subscriber)

City: _____

State: _____ Zip: _____

Email: _____

Primary Phone: (_____) _____

Sex: ☐ Male ☐ Female Birthdate: _____

Patient's Relationship to Subscriber:

☐ Spouse ☐ Child ☐ Other: _____

Do you also have another medical insurance plan?

☐ Yes ☐ No If Yes: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I am covered by the above listed medical insurance and I agree to assign all benefits, if any, otherwise payable to me directly to the provider of care for services rendered to me. I understand that I am financially responsible for all charges whether or not paid by insurance.

I authorize the use of my signature on all insurance submissions.

The doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining verification of insurance eligibility, determining insurance benefits payable for services and for obtaining payment for services provided to me.

I understand that my insurance may only pay a portion of the fee for the services provided. I understand that there may be a co-payment required at the time of my visit and there may be a balance remaining (or co-insurance) for which I am personally responsible for paying. I understand that co-payments are due and must be paid at the time of my visit.

_____
Signature of person assigned with financial responsibility for patient.

_____
Print the name of the person assigned with financial responsibility for patient.

_____ _____
Date Relationship to Patient

Arlington Heights
125 East Central Rd
Arlington Heights, IL 60005
(847) 398-7204

Chicago
5600 W. Addison St. (LL 2)
Chicago, IL 60634
(773) 545-3338

Referral

How did you hear about the practice? (select one)

☐ Google/Internet ☐ Friend/Family ☐ Insurance ☐ Facebook

☐ Doctor Referral (who?) _____

Medical History Form (1)

Name: _____
Last, Name, First Name

PRESENT ILLNESS OR INJURY
What is the reason (problem) for your visit to our office?

_____

_____

_____

_____

Who is your Primary Care Physician? (i.e internist)

_____

Have you seen this or any another physician regarding this problem?
☐ Yes ☐ No

If Yes, please list: Doctor: _____

Date last seen by this Doctor: _____

How were you referred to our practice?

☐ Another doctor ☐ Listed in your insurance guide

☐ Friend ☐ Family member ☐ Advertisement

Other (explain): _____

MEDICAL HISTORY

What is your current smoking status?

☐ Current every day smoker ☐ Current some day smoker

☐ Former smoker ☐ Never smoked

Please indicate which foot/ankle problems you now have or have had in the past:

☐ Ankle Pain
☐ Athlete's Foot
☐ Bunions
☐ Corns and Calluses
☐ Cramps in Feet /Legs
☐ Flat Feet
☐ Heel pain
☐ Ingrown Nails
☐ Numbness in Feet, Legs, Toes
☐ Plantar Warts
☐ Swelling in Feet, Legs, Toes
☐ Tired Feet

Have you been diagnosed with any of the following?

(you must indicate Yes or No)	Yes	No
Diabetes	☐	☐
Hypertension	☐	☐
Peripheral Vascular Disease	☐	☐
Onychomycosis	☐	☐
Plantar Fasciitis	☐	☐

Have you been prescribed foot orthotics? ☐ Yes ☐ No

If yes, do you still use them? ☐ Yes ☐ No

ALLERGIES

Please tell us of any allergies you have and potential reactions (i.e nausea, hives) when encountered:

☐ Aspirin: _____

☐ Codeine: _____

☐ Demerol: _____

☐ Iodine: _____

☐ Novocain: _____

☐ Penicillin: _____

☐ Sulfa: _____

Other: _____

MEDICATIONS

Please list any medications you are currently taking. If you require more space or would like a list of common medications please ask our receptionist to provide one.

_____

_____

_____

_____

_____

SURGICAL / INJURY HISTORY

List the type of surgery and date:

_____

_____

_____

_____

List any injuries that required medical attention or hospitalization and the date:

_____

_____

_____

Medical History Form (2)

Name: _____
Last, Name, First Name

PATIENT HISTORY

Please mark Yes or No to indicate you have/have not had any of the following:

	Yes	No		Yes	No		Yes	No
AIDS/HIV	☐	☐	Epilepsy	☐	☐	Rash	☐	☐
Allergies to Anesthetics	☐	☐	Eye Problems	☐	☐	Respiratory Disease	☐	☐
Allergies to Medicine or Drugs	☐	☐	Fainting	☐	☐	Rheumatic Fever	☐	☐
Anemia	☐	☐	Foot or Leg Cramps	☐	☐	Shortness of Breath	☐	☐
Angina	☐	☐	Gout	☐	☐	Sinus Problems	☐	☐
Arthritis	☐	☐	Headaches	☐	☐	Special Diet	☐	☐
Artificial Heart Valves or Joints	☐	☐	Heart Disease	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Hemophilia	☐	☐	Swelling in Ankles, Feet	☐	☐
Back problems	☐	☐	Hepatitis or Jaundice	☐	☐	Swollen Neck Glands	☐	☐
Bleeding Disorders	☐	☐	High Blood Pressure	☐	☐	Tired Feet	☐	☐
Cancer	☐	☐	Kidney Problems	☐	☐	Tuberculosis	☐	☐
Chemical Dependency	☐	☐	Liver Disease	☐	☐	Ulcers	☐	☐
Chest Pain	☐	☐	Low Blood Pressure	☐	☐	Varicose Veins	☐	☐
Chronic Diarrhea	☐	☐	Neuropathy	☐	☐	Venereal Disease	☐	☐
Circulatory Problems	☐	☐	Phlebitis	☐	☐	Weight Loss, Unexpected	☐	☐
Diabetes	☐	☐	Psychiatric Care	☐	☐			
Ear Problems	☐	☐	Radiation Treatment	☐	☐			

Is there a history in your family of any of the conditions shown above? ☐ Yes ☐ No

If yes, please describe. Also indicate the relationship.

_____

_____

_____

Are you now or have you been under another doctor's care for any reason in the last two years?

☐ Yes ☐ No

If yes, for what reason? _____

_____

What is your shoe size? _____

What is your last known height? _____

What is your last known weight? _____

What is your last known Blood Pressure? _____

PHARMACY

What is your preferred pharmacy?

Name: _____

Location: _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____
Signature of patient, guarantor or responsible party

_____
Print name of person whose signature appears

_____ _____
Date Relationship to Patient

☐ ☐ ☐ ☐

Kondiles Chicagoland Foot Care
Patient Financial Obligations

Kondiles Chicagoland Foot Care is dedicated to providing the best possible care and service to our patients in a cost effective manner. We regard patient's prompt handling of their financial responsibility as essential to ensure that we can provide quality services. In order to accomplish this, we depend upon prompt payment for the services we provide. To reduce any misunderstanding, we have adopted the following policy.

Payment options if you have insurance:
Kondiles Chicagoland Foot Care has made prior arrangements most insurance companies and health plans to accept assignment of benefits. We will file a claim with all insurance companies we participate with. Please be advised that unreported changes in medical insurance could result in billing delays, rejections, and personal responsibility for the services provided.

Financial Responsibilities:

- **A.** **You will need to pay your deductible, co-pay, and any determined out-of-pocket portions at the time of service.** Unpaid co-pays will be reported to your carrier since this is a requirement of your insurance plan, and may affect your coverage.
- **B.** If **Kondiles Chicagoland Foot Care** does not have a contract with your insurance company, you will be given an itemized statement to file with your insurance plan and will be responsible for the charges at the time of service.
- **C.** **Bring your current insurance information to each visit.** Failure to provide complete and accurate insurance information may result in patient responsibility for the entire bill. **It is your responsibility to understand your insurance benefits to include deductible amounts.**
- **D.** In the event that your health plan considers the service to be a "non-covered" benefit, you will be responsible for the charges at the time of service. If we are unable to verify coverage, you will be asked to sign a waiver that these charges may not be covered and you will be responsible for prompt payment of the all uncovered services.
- **E.** You should understand that your failure to meet your financial obligations to **Kondiles Chicagoland Foot Care** may include (but not limited to) additional actions such written correspondence, collection activities, reporting to outside credit bureaus, and termination of your patient relationship with **Kondiles Chicagoland Foot Care.**
- **F.** The undersigned also agrees to pay all collection costs incurred, in an amount not to exceed fifty percent (50%) of the unpaid balance, should any unpaid balance be referred to a collection agency, in addition, should any unpaid balance due be referred to an attorney for litigation, all responsible attorney fees and court fees and court costs shall be paid for by the undersigned as allowed by the Court.

Payment options for self-pay patients (co-pays, deductibles, balance after insurance or if you have no insurance):
Payment is expected on the day that treatment is rendered unless prior arrangements have been made. You can pay by cash, check, or (name the credit cards you accept). Alternative payment plans may be available for those patients who qualify (when made prior to your appointment). You may inquire about this with your **Kondiles Chicagoland Foot Care** financial representative at our office. We recommend that you sign our "Healthcare Credit Card Form" that authorizes us to charge your credit card any self-pay balance. Our financial representative will discuss that option at our office.

Patient Appointments: If you do not call within 24 hours to cancel an appointment, you will be charged $25.00. We make every effort to see our patients promptly, likewise we ask that you arrive 15 minutes before your scheduled time to register and complete paperwork so that your arrival time does not impact our ability to keep our schedule times with you or other patients. We ask that patients call the office promptly if you expect to be a late arrival, are unable to keep an appointment, or need to reschedule.

Minors: The parent(s) or guardian(s) accompanying a minor are responsible for payment. Minors must be accompanied by a parent of legal guardian to be treated. Any exception requires a signed "Authorization" to provide treatment.

Monthly Statement: If you have a balance on your account you will be billed promptly. It will show separately the patient balance due for each visit. The total due from you will be summarized at the bottom of the statement. Unless we approve other arrangements in writing, the balance on your statement is due upon receipt.

Billing Fees: Any balances not paid upon receipt of your statement will be assessed a monthly late charge at the rate of 1.5% of the outstanding balance of your account. **All returned checks will be charged a $30.00** administrative fee and your account will be placed on a cash only basis. Your late account may be turned over to a collection agency if payment arrangements are not made. You will be responsible for any costs including attorney fees, interest charges, and collection fees.

I HAVE READ THE ABOVE PATIENT OBLIGATIONS AND I AGREE TO FOLLOW THIS POLICY. ALSO, I UNDERSTAND THAT I SHOULD CONTACT Kondiles Chicagoland Foot Care FOR ASSISTANCE WITH BILLING QUESTIONS AT: (773) 545-3338.

Patients Name:_____

Signature:_____ **Date**_____**Relationship to patient**_____