Ankle N Foot Centers, LLC

Dr. George Tsatsos. • Dr. Svetlana Zats • Dr. Mariano Rivera • Dr. Kevin Massard • Dr. Telva Hernandez
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: 888-895-7225

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**:_____

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. **Height** _____ **Weight**_____**Shoe Size** _____
4. **Rate your Health**: Excellent ☐ Good ☐ Fair ☐ Poor ☐
5. Do / have you ever worn **custom foot orthotics**? Yes____ No____
6. **Primary Care Physician Name**: _____ **Phone**_____

   Date Last Seen: _____ **Reason**_____
7. Are you now, or have you been under **a physician or specialist care** during the **past two years**? Yes☐ No ☐

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

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

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

    No Known Allergies: ☐ _____
11. Are you subject to **prolonged bleeding**? Yes ____No ____
12. 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 Dr. George Tsatsos 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 have read a copy of the NOTICE OF PRIVACY PRACTICES and received financial policies of Ankle and Foot Centers and understand and agree to my patient rights and obligations.

☐ 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.

_____ _____

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

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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. **It is ultimately your responsibility to know your own benefits and to pay the balances as due.**
   e. **Treatments provided are medically necessary and will require payment.**

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 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 **30 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 25% 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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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** is providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a consultation or physical examination.
- **Payment** is such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects such as an internal review.

We may contact you to provide appointment reminders, information about treatment alternatives or results of tests taken.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, expect to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or locations. An example such as a different mailing address for statements or a different telephone number for communication.
- The right to inspect and copy your protected health information. The practice charges reasonable fees based on Illinois laws. If the requestor agrees to pay the fee in advance, the records will be provided. Otherwise, the records will not be provided, unless the Privacy Officer determines that the charge is burdensome to the requestor. The charges cannot exceed the following: $23.78 handling fee plus 0.89 cents each for pages 1-25, 0.59 cents each for pages 26-50, and 0.30 cents each for pages 51 to end.
- The right to amend your protected health information. The practice documents all requests, responds to the requests in a timely fashion, and informs requestor of denial in whole or in part.
- The right to receive an accounting of disclosures of protected health information. The practice allows an individual to request one accounting within a 12-month period free of charge. The practice charges a reasonable fee for more frequent account requests. The charge will be determined at the time of the request.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

The practice never requires an individual to waive any of his or her individual rights as a condition for the provision of treatment, except under very limited circumstances allowed under law.

You have the right to file a written complaint with our office, Attn: Privacy Officer, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Privacy Officer: Dr. George Tsatsos
Phone Number: 312-612-5000
Fax: (888) 895-7225
E-mail: info@anklenfoot.com
Address: 225 S. Jefferson
Chicago, IL 60661

_____ _____

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Credit Card Authorization From

Dear Patient,

Your signature authorizes the Ankle N Foot Centers Practice to bill your credit card or debit card shown for the following:

Non – Payment: Failure of insurance company to pay its portion within 45 days from the date of service.

Unpaid Balance: Account balances that are **45 days past due** from the date of service will have credit cards on file automatically **charged.**

Telephone Consultations: $75 charge for all telephone calls during non – patient hours. $45 charge during patient hours.

NSF Checks: $45 fee for retuned checks

Missed Appointment Fee: $35 fee for missed appointments without 24-hour notice

Missed Surgeries Fee: $375 fee for missed surgeries without 5 Days notice

Prescription Refill Request / Basic Form Fee: $25 fee for prescription refill requests

Disability / Workers Compensation Forms: $50-$125 fee for any form the physician is asked to complete-Time dependent

I realize that it is my responsibility to determine whether my provider at Ankle N Foot Centers is a participant of my insurance plan. I accept financial responsibility and understand it is my responsibility to provide Ankle N Foot Centers with updated information regarding my insurance coverage, home address, and telephone numbers.

I accept the responsibility to determine the details of my insurance plan such as copays, deductibles, co-insurance portions, maximum benefits, and exclusions. I agree to pay the copays, deductibles, coinsurance and balances I may accumulate due to non-payment by my insurance company.

I understand:

- It is the Ankle & Foot Centers' **policy to obtain credit card information for all new and returning patients.**
- Ankle & Foot Centers will keep my credit card information along with my signature on file. **All credit card information is confidential and safely secured through Transaction Express**.
- My credit card will automatically be charged for any **missed co-pays or missed appointment fees** (i.e. Fees that are customarily due on the date services are provided).

Patient's Name: _____

Patient's Signature: _____**Today's Date**:_____

Card Billing Address::_____**City**:_____**State**:___ **Zip**:_____

Credit Card #:_____**Exp Date**:_____ **Security Code**_____

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Patients Rights

You have the right to:

- Be treated with respect, consideration, and dignity.
- Be provided with appropriate privacy, according to HIPAA policies
- Know that patient disclosures and records are treated confidentially, and except when required by law, you are given the opportunity to approve or refuse their release.
- Be provided, to the degree known, with complete information concerning your diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
- Be given the opportunity to participate in decisions involving your health care, except when such participation is contraindicated for medical reasons.
- Be provided with information concerning:
- Patient conduct and responsibilities
- Services available at this organization
- Provisions for after-hours and emergency care
- Fees for services
- Payment policies
- Patient's right to refuse to participate in experimental research
- Methods for expressing grievances and suggestions to the organization
- Be informed of your right to change physicians.
- Know the marketing or advertising regarding the competence and capabilities of the organization is not misleading.
- Be provided with appropriate information regarding the absence of malpractice insurance coverage.

Patients Responsibility

You have the responsibility to:

- Provide current and accurate treatment and financial information.
- Follow the plan agreed upon by you and your physician in order to give you the best opportunity to improve.
- Inform the physician or clinic personnel of anything that you do not understand and will need further information.
- Discuss any concerns or doubts that you may have regarding your treatment plan.
- Cooperate with all clinic personnel in helping to implement and maintain the treatment plan that you have accepted.
- Follow all regulations of this organization regarding patient behavior and respecting the rights of other patients and our staff.