GURNEE PODIATRY & SPORTS MEDICINE ASSOC.

Treatment • Prevention • Rehabilitation

Lisa M. Schoene, DPM, ATC, FACFAS
Fellow, American College of Foot & Ankle Surgeons
Fellow, American College of Foot & Ankle Orthopedics & Medicine
Fellow, American Academy of Podiatry Sports Medicine
Certified Athletic Trainer

Bruce A. Bever, DPM
Physician, Surgeon & Specialist

WHICH OFFICE WILL YOU BE ATTENDING? ☐ CHICAGO ☐ PARK CITY

TODAY'S DATE: ______________________ PATIENT DATE OF BIRTH: ______________________

NAME
(LAST)______________________ (FIRST) ______________________ (MIDDLE) ______________________

GENDER ______________ MARITAL STATUS ______________ RACE ______________ ETHNICITY______________

ADDRESS: ____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE: ______________________ WORK:______________________ CELL:______________________

E-MAIL ADDRESS: ______________________ OCCUPATION /EMPLOYER:______________________

EMERGENCY CONTACT: ______________________ RELATIONSHIP: ______________________ PHONE#: ______________________

HOW DID YOU HEAR ABOUT OUR OFFICE/WHO REFERRED YOU? ______________________

PRIMARY CARE PHYSICIAN ____
(PLEASE PROVIDE NAME, ADDRESS, AND PHONE NUMBER)

(**MEDICARE PATIENTS ONLY**) DATE LAST SEEN BY YOUR PRIMARY CARE PHYSICIAN: ______________________

PREFERRED PHARMACY: ____
(PLEASE PROVIDE NAME, ADDRESS, AND PHONE NUMBER)

POLICY HOLDER INFORMATION

PRIMARY INSURANCE CO: ______________________ MEMBER ID#:______________________

POLICY HOLDER'S NAME**:** ______________________ DATE OF BIRTH: ______________________

RELATIONSHIP TO PATIENT**:** ______________________

SECONDARY INSURANCE? ______________________MEMBER ID#______________________

MINOR CHILDREN

PRIMARY RESPONSIBLE PARENT: ______________________ **RESIDES WITH:** MOM – DAD – BOTH – OTHER: ____________

ADDRESS: ____ PHONE#______________________

IF PARENTS ARE DIVORCED:

OTHER PARENT ADDRESS: ____ PHONE#______________________

I understand the HIPAA privacy rules regarding my personal, health, and medical information is available on www.Drschoene.com. I may request a copy from the office. My signature acknowledges acceptance of the privacy policies.

I give my permission for you to release my medical information to: ______________________ Relationship: ______________________

I give my permission for you to leave a message about my medical information on voice mail: YES ________ NO ________

Signature: ____ Date: ______________________

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Medical Questionnaire

Date: ____________________

Name____ Date of Birth: ________________________

1. Reason for today's visit? Please explain: ____

____

2. Have you seen any other foot & ankle specialists for this or any other condition?

____

3. Are you currently being treated for any of the following conditions? Please check all that apply…

☐ Anemia/blood disorders ☐ Allergies/Sinus/Bronchitis ☐ Arthritis ☐ Asthma/COPD

☐ Bladder/Kidney/Prostate ☐ Blood clots ☐ Cancer ☐ Depression/Anxiety ☐ Diabetes

☐ Chest Pain ☐COPD ☐Shortness of Breath ☐ Heart Disease ☐ High-Low Blood Pressure

☐ Eyes/Ears/Nose/Throat ☐ Headaches/Migraines ☐ Hepatitis ☐ HIV/AIDS

☐ Scarring ☐ Skin rash/Itching/Bruising ☐ Stomach pain/Ulcers/GERD ☐ Thyroid issues

☐ Weight loss/Weight gain ☐ Autoimmune ☐Lower Back/Orthopedic/Chiropractic

☐ Other Foot Conditions (please specify): ____

☐ Other: ____

4. Please list your medications: ____

____

5. Please list your supplements: ____

6. Are you allergic or have you reacted adversely to any medication? ☐YES ☐NO

If so, please list ____

7. Family History: ☐Diabetes ☐Stroke ☐Cancer ☐Arthritis ☐Heart Disease ☐ Foot Conditions ☐ Autoimmune

8. Please list any previous surgeries (include dates): ____

____

9. Social History:

☐Alcohol, Quantity per day/week: __________________

☐Smoking, Quantity per day/week: _____________ Have you recently quit? How long ago? ___________

☐Marijuana, Quantity per day/week: _________________

10. What is your current shoe size? ________________ Do you currently wear orthotics? ________________

11. Do you currently perform any physical activities? ☐ Walking ☐ Running ☐ Dancing ☐ Sports

Please specify type of activities: ____

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ASSIGNMENT OF BENEFITS-FINANCIAL AGREEMENT

AUTHORIZATION TO TREAT: I hereby give authorization to be seen & treated by the Doctors of Gurnee Podiatry & Sports Medicine/Sports Medicine Associates; Lisa M. Schoene DPM, and/or Dr. Bruce A. Bever. I also request that payment of authorized insurance benefits be made on my behalf to ***Lisa M. Schoene DPM, PC*** for any services rendered to me.

INSURANCE: Our office will submit a claim to your insurance company for any services rendered. When your insurance contracts with our office, they are legally obligated to pay our office in a timely manner. After 90 days, if the claim is not paid to our office after proper billing procedures have been followed, the balance becomes your responsibility. Our office participates with many insurance plans, network participation by our office does not mean services are covered by your plan. It is the member's responsibility to understand your insurance benefits; all co-insurance amounts, deductibles, non-covered items and co-pays are always your responsibility. Please note, for certain members, your health plan will begin issuing payment once your deductible has been met. Unless your insurance pays at 100% you will be responsible for any remaining co-insurance applied by your plan. We are required to bill you for any amounts deemed patient responsibility and nothing else. All pre-authorizations, referrals and/or second opinions are your responsibility to obtain. You are responsible to update our office with any changes to your current policy.

HMO/POS PLANS: These plans may require a referral by the patient's Primary Care Physician. All patients are responsible for obtaining the proper authorization PRIOR to your visit with our office. All benefits will be based on the information listed on the referral. Failure to obtain the appropriate referral may reduce the amount of benefits paid by the insurance company, making the balance your responsibility.

MEDICARE: Our office is a Medicare provider. Each patient is responsible for any deductible and co-insurance required by Medicare. If you have supplemental/secondary insurance our office will bill any remaining balance to that carrier for payment. If you do not have supplemental/secondary insurance you are responsible for any balance not covered by Medicare.

PAYMENTS: Payment for balances due, co-pays, deductibles, supplies and other non-covered items, etc., are due at the time of service. Payment can be made using cash, check or a credit card (Visa, Master Card & Discover). There will be $35.00 charge assessed for any returned checks. **If there is an overdue balance on the account, this, plus any co-pay, will be collected at the next visit. Your overdue balance, if not paid in a timely manner, will be assessed a late fee of $25 for every 30 days past due. If after 90 days payment isn't made, the account will be sent to a collection agency, any late fees or all attorney/court fees will be your responsibility.**

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for payment of all services. If the responsible (financial) party is different than the party accompanying the minor, proper information must be included on our registration form. For unaccompanied minors, non-emergency care will need to have prior authorization, in writing, by the parent or guardian. We must have this on file prior to the patient being treated.

ORTHOTICS/ DURABLE MEDICAL EQUIPMENT ITEMS: Our office will submit a claim to your insurance for certain DME items available in our office. You are responsible for the total charge minus any payments or adjustments applied by your plan. I understand that **any custom devices** dispensed by our office including but not limited to orthotics and braces cannot be returned for a refund as they are custom molded to each individual patient's foot. Once any Durable Medical Equipment item is dispensed it cannot be returned.

PHYSICAL THERAPY: The patient will be responsible to verify with their insurance company if physical therapy is a covered service at a **podiatry** office, or if it only covered at a licensed physical therapy office. Failure to obtain this prior verification may result in non-payment by the insurance company, making the balance your responsibility**.** Our office will collect your copay at the time of service. **SPA Massage** is not covered by insurance. Payment for this service is due at the time services are rendered.

MISSED APPOINTMENTS: As a courtesy, our office calls each patient 48 hours in advance to confirm all appointments. If it is necessary to cancel your appointment, we require a **24-hour cancellation notice**. This allows us to use that appointment time to accommodate other patients. **We will charge $50 for missed appointments without proper cancellation notice**.

SUPPLIES: For your convenience we stock many supplies that the doctor suggests for your treatment plan. We require that you pay for all supplies at the time of service. These supplies are not billable to insurance for payment.

CODING POLICY: Understand that this office can only code and file a claim for your visits with a diagnosis that was encountered and documented in your medical records. Thus, to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.

I hereby give authorization for payment of insurance to be made directly to ***Lisa M. Schoene, DPM, PC*** for services rendered. I have read this statement and understand the terms of my insurance and my financial obligations. The purpose of this form is to obtain consent for treatment and to authorize the collection and disclosure of your personal information relevant to your treatment. This information will be kept confidential and handled in accordance with HIPAA laws. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I certify that all information given is complete and accurate to the best of my knowledge.

Signature ____ Date: _____________________________________