

# GURNEE PODIATRY & SPORTS MEDICINE ASSOC.

**LISA M. SCHOENE, DPM, ATC, FACEAS**

FELLOW, AMERICAN COLLEGE OF FOOT & ANKLE SURGEONS  
 FELLOW, AMERICAN COLLEGE OF FOOT & ANKLE ORTHOPEDICS & MEDICINE  
 FELLOW, AMERICAN ACADEMY OF PODIATRIC SPORTS MEDICINE  
 CERTIFIED ATHELETIC TRAINER

**ERIN M. SMIELEWSKI, DPM, FACFAOM**

FELLOW, AMERICAN COLLEGE OF FOOT & ANKLE ORTHOPEDICS & MEDICINE  
 DIPLOMATE AMERICAN BOARD OF PODIATRIC MEDICINE  
 PHYSICIAN, SURGEON & SPECIALIST

DATE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

NAME (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MIDDLE) \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ LANGUAGE \_\_\_\_\_ RACE \_\_\_\_\_ ETHNICITY \_\_\_\_\_

ADDRESS \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_ EMERGENCY CONTACT \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ (NAME) \_\_\_\_\_ (PHONE) \_\_\_\_\_

SPOUSES NAME \_\_\_\_\_ PHONE# \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR OFFICE/WHO REFERRED YOU? \_\_\_\_\_

**MINOR CHILDREN:**

PRIMARY RESPONSIBLE PARENT \_\_\_\_\_ RESIDES WITH: MOM – DAD – BOTH – OTHER: \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE# \_\_\_\_\_

**IF PARENTS ARE DIVORCED:**

OTHER PARENT ADDRESS \_\_\_\_\_ PHONE# \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE# \_\_\_\_\_

**MEDICAL**

REASON FOR VISIT \_\_\_\_\_

ARE YOU PHYSICALLY ACTIVE OR AN ATHLETE?  YES  NO

WHAT ACTIVITIES / SPORTS DO YOU PARTICIPATE IN \_\_\_\_\_

**INSURANCE INFO: POLICY HOLDER INFORMATION**

PRIMARY INSURANCE CO? \_\_\_\_\_ MEMBER ID# \_\_\_\_\_

PRIMARY INSURED NAME \_\_\_\_\_ DOB # \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

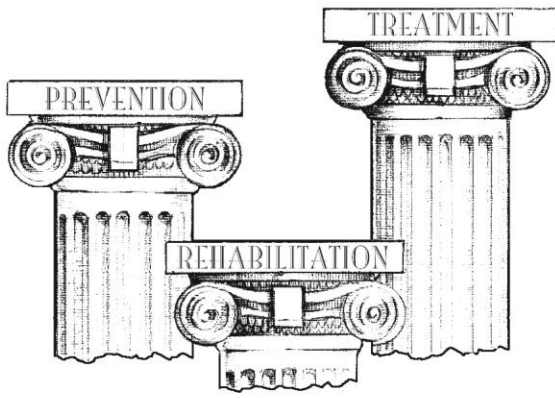
SECONDARY INSURANCE? \_\_\_\_\_

I understand the HIPAA privacy rules regarding my personal, health, and medical information is available on [www.Drschoene.com](http://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

Name \_\_\_\_\_ Date: \_\_\_\_\_

For the following questions, check yes or no. Your answers are for our records only and are considered confidential.

1. What medical illnesses do you have? Explain: \_\_\_\_\_

2. List your medications, including supplements: \_\_\_\_\_

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

a. If so, please list \_\_\_\_\_

4. Family History (please check all that apply)

Diabetes  Heart attack/Heart disease  Arthritis  Stroke  Foot Problems

Other (Please explain) \_\_\_\_\_

5. What is your shoe size? \_\_\_\_\_ What type of shoes do you wear? \_\_\_\_\_

6. Do you wear orthotics?  YES  NO

7. Who is your physician? (Include name, address and phone number) \_\_\_\_\_

8. Have you had any surgery in the past?  YES  NO

If so, please list: \_\_\_\_\_

9. Do you smoke or have you in the past 10 years?  YES  NO If so, how much? \_\_\_\_\_

10. Do you consume alcohol?  YES  NO If so, how much? \_\_\_\_\_

11. Do you have any problems with:

a. Eyes, ears, throat, thyroid? .....  YES  NO

b. Weight gain, loss, insomnia?.....  YES  NO

c. Allergies, sinus, asthma, bronchitis? .....  YES  NO

d. Chest pains, shortness of breath, heart attack, high blood pressure?.....  YES  NO

e. Stomach ulcers, pain, reflux indigestion?.....  YES  NO

f. Bladder, kidney, prostate/uterus?.....  YES  NO

g. Skin rash, itch, redness, bruising?.....  YES  NO

h. Arthritis, back pain, old fractures?.....  YES  NO

i. Headaches, migraines, seizures?.....  YES  NO

j. Anemia, blood disorders, bleeding tendencies? .....  YES  NO

k. Other? \_\_\_\_\_  YES  NO

12. Are you under the care of any other physician? (Chiropractor, Specialist, etc.)  YES  NO

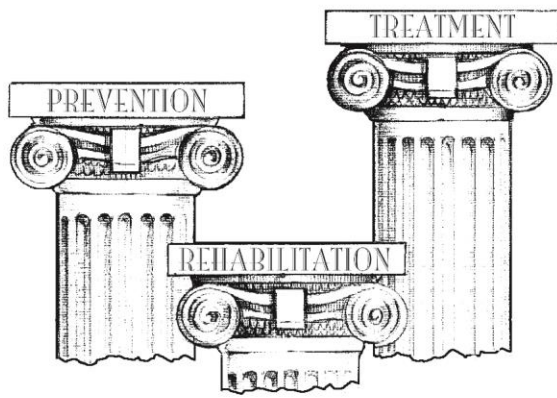
Explain: \_\_\_\_\_

351 S. GREENLEAF ST. STE #C  
 PARK CITY, IL 60085

(847) 263-6073 • FAX (847) 244-7323

401 W. ONTARIO ST. STE #240  
 CHICAGO, IL 60654

(312) 642-6020 • FAX (312) 642-6080



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## Patient Agreement

**ORTHOTICS:** I have thoroughly read & understand the orthotic policy. I understand that returns for orthotics are **NOT** accepted. Our orthotics are custom molded to each patient's individual foot. Once your order is placed with our lab and the orthotics are fabricated, we cannot cancel.

**REFURBISHING OF ORTHOTICS:** You are responsible for the full amount on any refurbishing charge for orthotics.

**NIGHT SPLINT/ BRACES:** These are durable medical goods and may not be covered in full by your insurance company. We will bill the insurance company for your benefit. However, you are responsible for the total charge less any insurance payment. **NIGHT SPLINTS CANNOT BE RETURNED ONCE THEY ARE DISPENSED. BRACES CANNOT BE RETURNED AS THEY ARE CUSTOM MOLDED FOR EACH PATIENT.**

**PHYSICAL THERAPY:** (Solo or multiple services): Your insurance company may require a co-pay. We will collect your known co-pay at the time of service. If necessary a refund will be issued. Please check with your insurance to see if IN OFFICE physical therapy is a covered benefit of your policy.

**SPA MASSAGE:** Insurance companies will not cover this treatment. Payment will be due at time of service.

**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 fully understand that I am responsible for the above mentioned.***

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

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WWW.DRSCHOENE.COM

05/2018

**Lisa M. Schoene, DPM, PC**  
**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 **Erin M. Smielewski DPM**.

**INSURANCE:** If we are a participating provider with your insurance plan, we will submit our claim to your insurance plan directly for reimbursement. **You are responsible to update our office with any changes to your current policy.** 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. **It is your responsibility to understand your insurance policy completely; all co-insurance amounts, deductibles, non-covered items and co-pays are always your responsibility. All pre-authorizations, referrals and/or second opinions are your responsibility to obtain.**

**HMO/POS PLANS:** These plans may require a referral by the patient's Primary Care Physician. **All patients are responsible for obtaining the proper referral PRIOR to the visit to our office.** All benefits will be based on the proper information 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:** We do participate with Medicare. Each patient is responsible for the deductibles required by Medicare. Our office will collect these at your first office visit of each year. If you have supplemental/secondary insurance our office will bill the 20% to that insurance after Medicare reimburses our office. **If you do not have supplemental/secondary insurance you are responsible for the 20% charge for each visit.** Any balances due are your responsibility.

**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 balances, if not paid in a timely manner, will be turned over to our collection agency. **A collection fee of 30% of the total owed will be assessed when sent to collections and any or all attorney 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:** I understand that custom 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.**

**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. We do not bill your insurance for these supplies.

**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.

Signature \_\_\_\_\_ Date: \_\_\_\_\_