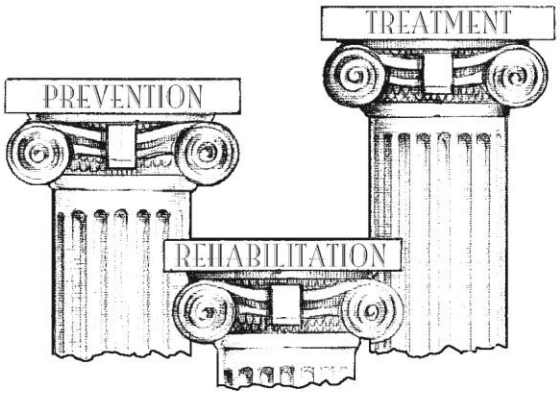


GURNEE PODIATRY & SPORTS MEDICINE ASSOC.

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 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_____
(NAME) (PHONE)
EMPLOYER_____ OCCUPATION_____

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 #_____

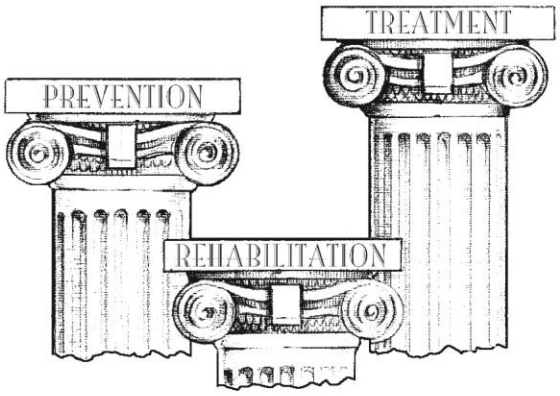
RELATIONSHIP TO PATIENT_____

SECONDARY INSURANCE? _____

I understand the HIPAA privacy rules regarding my personal, health, and medical information is available on **www.Drschoene.com**. 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:

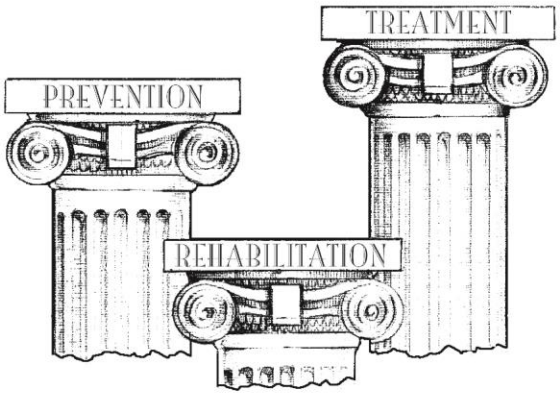
a. Eyes, ears, throat, thyroid?	☐YES	☐ NO
b. Weight gain, loss, insomnia?.....	☐YES	☐ NO
c. Allergies, sinus, asthma, bronchitis?	☐YES	☐ NO
d. Chest pains, shortness of breath, heart attack, high blood pressure?.....	☐YES	☐ NO
e. Stomach ulcers, pain, reflux indigestion?.....	☐YES	☐ NO
f. Bladder, kidney, 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

WWW.DRSCHOENE.COM



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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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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: _____