Dr. Camilleri, DPM
Dr. Oaks, DPM
Dr. Komarov, DPM

**Ridgeland Foot & Ankle Center**

RidgelandFoot.com
6845 STANLEY AVE. BERWYN, IL 60402
T: (708) 788-5232 F: (708) 788-3618

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| First Name: | Middle Name: | Last Name: | |
| Social Sec.#: | Date of Birth: / / | Age: | Sex: M F |
| Home Address: | | | |
| City: | State: | Zip Code: | Email: |
| Home Phone: ( ) | Cell Phone: ( ) | Work Phone: ( ) | |
| Preferred Method of Written Communication (Please circle one): Email Mail Fax: ( ) | | | |
| (Please provide mailing address if different from above): | | | |
| Preferred Method of Verbal Communication (Please circle one): Home Phone Work Phone Cell Phone | | May we leave a message?: Yes No | |
| Race: (optional) | Ethnicity: (optional) | Marital Status: S M D W | Driver's License #: |
| Occupation: | | Employer: | |
| Employer Address: | | | |
| Primary Physician: | | Phone: ( ) | |
| Referred by: | | | |

## IN CASE OF EMERGENCY CONTACT

| | |
|---|---|
| Last Name: | First Name: |
| Relationship: | Phone: ( ) |

## PREFFERED PHARMACY

| | | | |
|---|---|---|---|
| Name of Pharmacy: | Phone: ( ) | | |
| Address (or cross streets): | City: | State: | Zip Code: |

## INSURANCE INFORMATION

| | | |
|---|---|---|
| Name of Insured: | DOB: / / | Relationship: |
| Primary Insurance: | Phone: ( ) | |
| Subscriber #: | Group #: | |

I the undersigned, authorize DR _____ to examine and treat my feet medically, surgically, or biomechanically. I hereby assign my insurance benefits to be paid directly to TOWER PODIATRY and I am responsible for any unpaid balance. I authorize the release of any medical information necessary to process all claims.

_____ _____

Patient Signature Date

_____ _____

Patient's Guardian or Representative's Signature
*IF PATIENT IS A MINOR (UNDER 18) OR UNABLE TO SIGN OWN CONSENT*

Relationship
*IF SIGNED BY PATIENT'S GUARDIAN OR REPRESENTATIVE*

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**Chart #:** _____ **Print Patient Name:** _____

## MEDICAL HISTORY

| |
|---|
| WHAT BROUGHT YOU TO SEE THE DOCTOR? (Please provide a brief description of the nature of the illness / injury.) |
| WHEN DID YOUR SYMPTOMPS BEGIN? |
| WHAT TREATMENTS HAVE YOU TRIED? |
| WHAT OTHER FOOT / ANKLE / LEG PROBLEMS DO / DID YOU HAVE? |

| | | | |
|---|---|---|---|
| **ALLERGIES:** Do you have any allergies? | 1. | 2. | 3. |
| **MEDICATIONS:** What medications are you currently taking? | | | |
| 1. | 6. | 11. | 16. |
| 2. | 7. | 12. | 17. |
| 3. | 8. | 13. | 18. |
| 4. | 9. | 14. | 19. |
| 5. | 10. | 15. | 20. |

## PAST MEDICAL HISTORY

Indicate whether you have had any of the following medical problems:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Heart Disease | | | Arthritis | | |
| Heart Valve Replacement | | | Gout | | |
| Heart Attack | | | Fibromyalgia | | |
| Chest Pain | | | Osteoporosis | | |
| Pacemaker | | | Leg Pain | | |
| High Blood Pressure | | | Back Pain | | |
| High Cholesterol | | | Weakness In Extremities | | |
| Stroke | | | Numbness In Extremities | | |
| Shortness Of Breath | | | Balance Problems | | |
| Lung Disease | | | Dizziness | | |
| Asthma | | | Headaches/Migraines | | |
| Sleep Apnea | | | Changes/Loss Of Vision | | |
| Liver Disease | | | Stomach Ulcer | | |
| Hepatitis | | | Tuberculosis | | |
| Bleeding Disorder | | | HIV | | |
| Clotting Disorder | | | Cancer (Type?) | | |
| Anemia | | | Thyroid Condition | | |
| DVT (Blood Clot) | | | Pregnant | | |
| Kidney Disease | | | Diabetes | | |
| Fractures (When/Where?) | | | Type I ___ Type II ___ | | |
| Joint Replacement (Which?) | | | Skin Conditions (What?) | | |

## FAMILY HISTORY

Check if any family members have/had any of the following:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Bleeding Disorder | | | Gout | | |
| Cancer | | | Arthritis | | |
| Heart Trouble | | | Bunion | | |
| High Cholesterol | | | Bunionette | | |
| High Blood Pressure | | | Flat Feet | | |
| Stroke | | | High Arched Feet | | |
| Diabetes | | | Pigeon-Feet | | |
| Other (Please specify): | | | | | |

## SOCIAL HISTORY

| | Yes | No | what kind,how much, how often? |
|---|---|---|---|
| Do you smoke? | | | |
| Did you ever smoke? | | | |
| Caffeine? (tea /coffee) | | | |
| Illicit drug use? | | | |
| Alcohol use? (Current or past) | | | |
| Exercise regularly? | | | |

## PAST SURGICAL HISTORY

| Procedure | Date | Surgeon | Complication |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

**HEIGHT:** _____ **WEIGHT:** _____ **SHOE SIZE:** _____

*I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THAT THE INFORMATION PROVIDED IS TRUE AND ACCURATE AND I HAVE DISCLOSED ALL PERTINENT MEDICAL HISTORY.*

_____ _____

Patient Signature Date

_____ _____

Patient's Guardian or Representative's Signature
*IF PATIENT IS A MINOR (UNDER 18) OR UNABLE TO SIGN OWN CONSENT*

Relationship
*IF SIGNED BY PATIENT'S GUARDIAN OR REPRESENTATIVE*

**Print Patient Name**: _____

# FINANCIAL POLICY

Thank You for choosing Ridgeland Foot and Ankle Center as your health care provider. We are committed to your treatment being successful. The Following is a statement of our Financial Policy that we ask you to read, agree to and sign prior to any treatment.

1. Payment is due at the time services are rendered, including co-payment, deductibles and previous balances. We do bill insurance plans as a courtesy, but it is not a guarantee of payment. We accept cash, check, Visa, MasterCard and Discover.
2. It is your responsibility to verify with insurance plan/carrier prior to each appointment that our group and the individual doctor is a participating provider. Please verify if any services such as office visits, X-rays, and procedures require pre-authorization. Some plans require pre-authorization or referrals from the patient's family physician.
3. Written or verbal authorizations from insurance plans or management groups are not a guarantee of payment. All claims are reviewed by the insurance carriers after services are rendered and authorizations can be denied at the time of review. Denied claims become the patient's responsibility.
4. Statements are mailed after the insurance company has paid their portion. The account is then payable within 30 days. Overdue accounts are subject to a $15 fee. Accounts 90 days in arrears will be subject to collection by an external agency unless financial arrangements are made with our office.
5. All supplies and products dispensed which are not billable to insurance must be paid for at the time they are dispensed.
6. We recommend you verify with your insurance carrier whenever our office refers you to outside laboratories, hospitals, physical therapy or tests to insure that you do not require any pre-authorization.
7. There is a $35.00 charge for any and all forms filled by our office. Please allow 7 days for completion of forms.
9. We understand that some appointments cannot be kept due to unforeseen circumstances. However, we ask for a 24-hour notice so that time can be rescheduled for another client. Our policy is to charge $50.00 for an appointment that is cancelled with less than 24-hour notice.
10. If for any reason you are more than 15 minutes late, we may have to reschedule your appointment.

*I HAVE READ TH ABOVE AGREEMENT AND AGREE TO THE TERMS AND CONDITIONS AS SET FORTH BY RIDGLEAND FOOT AND ANKLE CENTERS.*

_____ _____

Patient Signature Date

_____ _____

Patient's Guardian or Representative's Signature
*IF PATIENT IS A MINOR (UNDER 18) OR UNABLE TO SIGN OWN CONSENT*

Relationship
*IF SIGNED BY PATIENT'S GUARDIAN OR REPRESENTATIVE*

**Print Patient Name**: _____

# Your Rights Regarding Your Health Information

1. *Communications*. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care, such as family members and friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to RFAAC Podiatry.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our office. You must provide us with a reason that supports your request for amendment.

5. You have the right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front office receptionist.

6. You have the right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, RFAAC, all complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. You have the right to provide an authorization for other uses and disclosures. Our practice will obtain written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

8. Any pictures taken from me at RFAAC will solely be used for purposes of electronic medical chart keeping and will not be shared with any marketing and/or advertising agency, unless requested by any federal or state governmental agency.
If you have any questions regarding this notice or our health information privacy policies, please contact Ridgeland Foot and Ankle Center.

*I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF RIDGELAND FOOT AND ANKLE CENTER'S NOTICE OF PRIVACY PRACTICES.*

_____ _____
Patient Signature Date

_____ _____
Patient's Guardian or Representative's Signature
*IF PATIENT IS A MINOR (UNDER 18) OR UNABLE TO SIGN OWN CONSENT*

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