ADVANCED ANKLE and FOOT SURGEONS, LLC

4905 Stone Falls Center, Suite B
O'Fallon, IL 62269
Office Phone: 618-277-0001
Office Fax: 618-277-7339

211 East Hanover Street
New Baden, IL 62265
Office Phone: 618-277-0001

Thank you for choosing **Advanced Ankle and Foot Surgeons, LLC** as your healthcare partner. We value communication, beginning with the new patient registration process. The information in this packet will help you prepare for your first visit to our office.

Your packet contains directions to our office and general information about our office policies and procedures. Also included are several forms for you to complete and bring with you to the appointment, and an Authorization for Disclosure of Health Information form to complete and send to your previous doctor.

☐ Please complete the following forms and **bring them to your appointment**.
Patient Registration, Communication Authorization, Financial Policy, and Patient Health History

☐ Bring your insurance card(s) and a photo identification card to your appointment.
Please bring a valid referral, if required by your insurance company, and be prepared to pay your copayment, or coinsurance as required by your insurance carrier.
If you are not prepared to pay your copayment or if you do not have a valid referral form, we may ask y*ou to reschedule your appointment.*

☐ Please plan to arrive at the office at least **15 minutes prior** to your scheduled appointment time to allow ample time to complete the registration process.
If you fail to keep your new patient appointment and do not notify the office 24 hours prior, we cannot reschedule your visit.

Again, we thank you for choosing our practice and we look forward to working with you to achieve your healthcare goals We encourage you to call the office if you have any questions about the information contained in this packet.

Dr. James Taylor and Staff

ADVANCED FOOT and ANKLE SURGEONS, LLC

REGISTRATION FORM

CHART#

GENERAL INFORMATION						
First Name		**Middle Name**		**Last Name**		
SSN	**Birth Date**	**Gender** ☐ Male ☐ Female		**Preferred Name**		
ADDRESS and PHONE						
Home Address				**Zip code**		
Home Phone	Area code	Number	**Work Phone**	Area code	Number	Extension
Cellular Phone	Area code	Number	**Preferred Phone** ☐ Home ☐ Work ☐ Cellular			
Preferred method of communication ☐ Phone ☐ Mail ☐ Email						
Mailing Address *(if different from home address)-*				**Zip code**		
Email Address						
OTHER						
How did you hear about us?	☐ Dr. ☐ Insurance ☐ Internet/Google ☐ Facebook ☐ Friend/Family ☐ Newspaper ☐ Billboard					
Race	**Ethnicity:** ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Unreported/Refused					
Preferred Language ☐ English ☐ Spanish ☐ Other			**Do you need an interpreter?** ☐ Yes ☐ No			
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner						
Employment ☐ Full-Time ☐ Part Time ☐ Not Employed			**Employer**			

PRIMARY INSURANCE			
Insurance Plan Name			
Subscriber ID		Group Number	
Effective Date		Group Name	
Insured's Name		Date of Birth	
Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Partner		Social Security Number	

SECONDARY INSURANCE			
Insurance Plan Name			
Subscriber ID		Group Number	
Effective Date		Group Name	
Insured's Name		Date of Birth	
Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Partner		Social Security Number	

ASSIGNMENT OF BENEFITS

- I understand I am financially responsible for all charges and services provided to me, including the balance remaining after payment of potential insurance benefits. I authorize payment of medical insurance benefits to Advanced Ankle and Foot Surgeons, LLC for professional services rendered.
- I authorize the release of any information necessary to process this claim.
- I certify that all the above information is true and correct to the best of my knowledge. I give my permission to the Provider and/or medical staff to administer and perform such procedures deemed necessary in the diagnosis and/or treatment of my podiatric condition(s).

Signature of Patient / Legal Guardian/Representative	**Relationship**	**Date**

ADVANCED FOOT and ANKLE SURGEONS, LLC
PATIENT MEDICAL HISTORY and SYSTEMS REVIEW

PATIENT NAME (Last, First)	Birth Date:	Today's Date:
Height:	Weight	Shoe Size

PRIMARY CARE DOCTOR

Name	
Address	
Office Phone Number	Office Fax Number

REFERRING DOCTOR or FACILITY

Name	
Address	
Office Phone Number	Office Fax Number

PREFERRED PHARMACY

Name	Address, City, State, Zip Code	Phone Number

MEDICATIONS

Medication Name	Strength	Date Started	Directions	Ordering Provider

ALLERGIES

Allergen	Reaction

PREVIOUS SURGERIES

Type of Surgery	Date Performed	Outcome

REASON FOR TODAY'S VISIT

To the best of your ability, please describe your level of pain.

☐ *Burning* ☐ *Shooting* ☐ *Sharp* ☐ *Dull* ☐ *Aching* ☐ *Throbbing* ☐ *Superficial* ☐ *Deep*
☐ *Tingling* *Other (please describe)*

How long have you had pain?

# of Days	#Weeks	#Months	#Years

How long does your pain last?

# of Seconds	#Minutes	#Hours	#Days

What makes the pain worse?

☐ *Walking* ☐ *Running* ☐ *Standing* ☐ *Sitting* ☐ *Barefoot* ☐ *Resting* ☐ *Shoes* ☐ *Other-Describe below*

Have you suffered any trauma?	No ☐	Yes ☐	When?	Describe

Describe any previous treatment and/or other information that will help us treat your condition.

Please complete both sides of this form.

SOCIAL HISTORY	
Occupation	
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner
Tobacco Use	☐ **No**
	☐ **Yes** ☐ Cigarettes ☐ Cigars ☐ Other _____ Number of years you have smoked? _____ Number smoked per day _____
	☐ **Former smoker** When did you quit?
Caffeine Use	☐ **No** ☐ **Yes** Amount per day?
Alcohol Use	☐ **No** ☐ **Yes** Number of drinks per week?
Do you use drugs not prescribed for a medical condition(s)? ☐ **No** ☐ **Yes** If **Yes**, please describe:	
Do you exercise? ☐ **No** ☐ **Yes** – how often? Describe type of exercise	
HEALTH MAINTENANCE	
Date of last eye exam?	

MEDICAL SYSTEMS REVIEW: ***Please check any medical conditions that apply to you.***

General
- ☐ Recent Weight Gain
  Amount _____
- ☐ Recent Weight Loss
  Amount _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

Nervous System
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle Spasm
- ☐ Loss of Consciousness
- ☐ Sensitivity or Pain in hands/feet
- ☐ Memory Loss

Ears
- ☐ Loss of Hearing

Eyes
- ☐ Loss of Vision
- ☐ Double or Blurred Vision

Neck
- ☐ Swollen Glands
- ☐ Tender Glands

Heart and Lungs
- ☐ Pain in Chest
- ☐ Irregular Heart Beat
- ☐ Sudden Changes in Heart Beat
- ☐ Shortness of Breath
- ☐ Difficulty Breathing at Night
- ☐ Swollen Legs or Feet
- ☐ High Blood Pressure
- ☐ Heart Murmurs
- ☐ Cough
- ☐ Coughing of Blood
- ☐ Wheezing
- ☐ Night Sweats
- ☐ High Cholesterol

Stomach and Intestines
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting of blood
- ☐ Vomiting of material looking like coffee grounds
- ☐ Stomach pain relieved by food or milk
- ☐ Yellow jaundice
- ☐ Increasing constipation
- ☐ Persistent Diarrhea
- ☐ Blood in stool
- ☐ Heartburn

Kidney / Urine / Bladder
- ☐ Difficult urination
- ☐ Frequent urination
- ☐ Pain/burning when urinating
- ☐ Blood in urine
- ☐ Cloudy/smoky urine
- ☐ Getting up at night to urinate

Blood
- ☐ Anemia
- ☐ Bleeding tendency

Skin
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Tightness
- ☐ Nodules, Bumps
- ☐ Hair loss
- ☐ Color changes of hand/feet in the cold

Muscles / Joints / Bones
- ☐ Morning stiffness, lasting _____ Min_____Hours
- ☐ Joint pain
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling
- ☐ List all joints affected over the past 6 months

  _____

  _____

  _____

Other Conditions
- ☐ Diabetes: Insulin dep
  Year diagnosed:_____
- ☐ Diabetes: Non-insulin dep
  Year diagnosed:_____
- ☐ Parkinson's disease
- ☐ Alzheimer's Disease

ADVANCED ANKLE and FOOT SURGEONS, LLC
GENERAL PRACTICE INFORMATION

Because we value open communication and mutual respect, we created this Practice Information Guide to help make your visits here convenient, pleasant, and beneficial.

OFFICE HOURS - BELLEVILLE

Monday	7:30-4:00
Tuesday	CLOSED
Wednesday	7:30-4:00
Thursday	CLOSED
Friday	CLOSED

OFFICE HOURS - O'FALLON

Monday	7:30-4:00
Tuesday	7:30-5:30
Wednesday	1:00-4:00
Thursday	7:30-4:00
Friday	7:30-3:00

APPOINTMENTS

- We strive to minimize wait times and to spend as much time as needed to address your medical concerns. For this reason, we see our patients by appointment and strongly discourage walk-in visits.
- We room patients in appointment-time order. Expect the doctor to treat the primary reason for the scheduled office visit; we may ask you to schedule another appointment to address concerns other than the primary reason for your visit.
- If you arrive more than 15 minutes after your scheduled appointment time, we will do our best to assist you; however, we may ask you to reschedule.
- Please call the office 24 hours before your appointment if you need to cancel or reschedule. Dr. Taylor may ask you to find an alternate source of medical care if you repeatedly fail to keep your scheduled appointments.

REGISTRATION

- Please bring your insurance card, government issued photo ID and copayment to every visit.
- When you check in, tell us if you have any change in address, phone numbers, employer, or health insurance.
- It is your responsibility to know the coverage and requirements of your health plan regarding podiatry care, referrals, and durable medical equipment (DME).
- If you do not have a valid referral/authorization from your primary care doctor, you may be required to pay for the office visit in full, **OR** we may implement a payment plan, at Dr. Taylor's discretion.
- **Our providers do not contract with any Illinois Medicaid plan**.
- Please come prepared with the social security number and birthdate of the individual subscriber for your or your child's, insurance plan.
- **For minor children, we name the custodial parent as the responsible party for payment of patient-responsible balances.**

PERSONAL HEALTH INFORMATION

- **We charge $10.00 to complete medical-care related forms (for example, FMLA, disability, etc.). This fee is payable when you present the form in the office. We must receive payment, either in person or by credit card over the phone, for all requests received by fax or by mail.**
- We must have a signed, HIPAA-compliant authorization to release copies of your medical records.

4600 Memorial Drive, Suite 80
Belleville, Illinois 62226-5359
Office Phone: 618-277-0001

4905 Stone Falls Center
O'Fallon, IL 62269
Office Phone: 618-277-0001

Office Fax: 618-277-7339

- We use a professional service to manage medical records requests and, according to Illinois law, if the request is for your personal use they may charge you a fee for copying those records. We do not charge for records transferred to another physical or medical facility for the purpose of continued care.
- Please allow at least 14 days from the receipt of the signed authorization to receive your records.

MEDICATION REFILLS

- Please allow 24-48 hours for our doctors to process your refill request. Ask your pharmacy to **fax** the request to
  618-277-7339.
- We authorize prescriptions for narcotic medications **during office hours only**. We may ask you to come for an office visit before we will authorize your refill request.

AFTER HOURS and EMERGENCY CARE

- If you experience a life-threatening medical condition after office hours, call 911 or go immediately to the nearest Emergency Department, even if you are out of town. If you have an urgent situation that cannot wait until regular office hours, you may reach Dr. Taylor on his pager at **618-321-1549**.

Your good health is important to us!
Thank you for choosing Advanced Ankle and Foot Surgeons.

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ADVANCED ANKLE and FOOT SURGEONS, LLC.

PATIENT FINANCIAL AGREEMENT

We strive to maintain a strong physician-patient relationship. Sharing our Financial Policy in advance allows for a good flow of communication and enables us to achieve our goal. If you have any questions, do not hesitate to ask a member of our staff.

Health Insurance

- **WE DO NOT PARTICIPATE WITH ANY STATE OF ILLINOIS MEDICAID PLAN.**
- Deductibles, copayment and co-insurance payments are your responsibility.
  DEDUCTIBLE (an amount you must pay first out of your own pocket each year before insurance begins paying for any services),
  COPAYMENT (an amount you must pay at each doctor's visit that is due at the time of service),
  CO-INSURANCE (an amount - usually a percentage of the office fees that your insurance company will not pay).
- We file claims with our contracted insurance plans only. Since the insurance contract is an agreement between you and your insurance company. It is your responsibility to understand your insurance plan benefits with regard to a covered service, if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure.
- If you have more than one insurance policy, it is your responsibility to inform the office which policy is **Primary** (first) coverage and which policy is **secondary** or **Tertiary**. With each policy, we require the name, birth date, address, phone number, and social security number of the individual who carries the policy.

I agree to provide a copy of my insurance card(s) at each visit with the name, address, phone number, date of birth and social security number of the individual who carries the insurance.

Patient/Responsible Party Initial _____

I agree to provide a valid authorization/referral. I understand that if I do not have a valid referral, the staff may ask me to reschedule or pay for the visit in full at check out.

Patient/Responsible Party Initial _____

General Financial Information

Required Payments: **Any copayment, co-insurance, or deductible required by your insurance company must be paid at time of service.** Because this is an insurance requirement, we **cannot** bill you for these amounts.

Patient/Responsible Party Initial _____

Returned Checks: There is a $25.00 fee for any check returned by the bank. We expect payment by cash, credit card, or money order within 14 days of the notice that your check was returned.

Patient/Responsible Party Initial _____

Past Due Balances: If your account becomes past due (4 or more statements), we will take necessary steps to collect this debt, including referral of your account to a collection agency. We offer monthly payment plans tailored to each individual's circumstances.

Patient/Responsible Party Initial _____

Treatment of Minor Children:

Children under the age of 18 years must have a parent, guardian or designated responsible party to provide authorization for treatment.

In the case of divorce or separation, it is the authorizing parent's responsibility to collect from the other parent.

It is the authorizing parent's responsibility to provide the office with the name, birthdate, social security number, address and phone number of the parent who carries the child's health insurance.

Patient/Responsible Party Initial _____

Workers' Compensation: We do not file worker's compensation claims. Please advise the office staff prior to rooming if you believe your condition is work-related.

Patient/Responsible Party Initial _____

Personal Injury: If you are receiving treatment as part of a personal injury claim or lawsuit, we require verification from your attorney **prior to your initial visit**. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be available. **Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to your personal injury.**

Patient/Responsible Party Initial _____

Completion of Forms: We charge a fee of **$10.00** to complete any forms not related to health insurance claims (disability, FMLA, injury, for example). Payment is due each time you deliver a form for completion. For forms received by fax or mail, we must receive your payment prior to returning the form to the requestor. We cannot bill you for this service.

Patient/Responsible Party Initial _____

By signing initialing and signing this form, you agree to all of the terms and conditions herein and the agreement will be in full force and effect.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Signature	Printed Name	Date

Responsible Party, if not the Patient	Printed Name	Date

On completion, we will provide you with a copy for your records.

ADVANCED FOOT and ANKLE SURGEONS, LLC
COMMUNICATION AUTHORIZATION

Patient Name _____
Last First MI Maiden

Date of Birth _____ **Social Security Number** _____

I authorize the providers and staff of Advanced Ankle and Foot Surgeons, LLC to discuss and disclose my Protected Health Information (PHI) to the person(s) named below.

Name	Relationship	Phone Number

I authorize the providers and staff of Advanced Ankle and Foot Surgeons, LLC to leave messages:

☐ _____ Initials — On my **home** answering machine / voice mail. _____ Phone Number

☐ _____ Initials — On my **cell phone** voice mail. _____ Phone Number

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HIPAA: NOTICE OF PRIVACY PRACTICES

I have received, and/or been provided the opportunity to receive, a copy of the "Notice of Privacy Practices" that explains when, where and why my confidential health information may be used or shared.

I acknowledge that the Advanced Ankle and Foot Surgeons, LLC physicians, medical assistants and other staff may use and share my confidential health information with others in order to 1) treat me, 2) to arrange for payment of my bill, and 3) for issues that concern Advanced Ankle and Foot Surgeons, LLC operations and responsibilities.

This authorization remains in force until revoked in writing. The purpose of this disclosure/use is for continued medical care.

_____ _____ _____
Signature of Patient, Guardian, Personal Representative Relationship Date

_____
Print name of person authorized under state law to act in the patient's behalf, if the patient is deceased, or his personal representative, or if none, of his child, parent or sibling.