Diana Emini, DPM
Michelle Kim, DPM

14236 McCarthy Rd, Lemont IL 60439
www.DMFootAndAnkle.com

Today's Date: / /

PATIENT INFORMATION FORM

Name		Preferred Name	
Gender ☐ M ☐ F	Birth Date / /	Social Security # - -	
Address		City	State
Zip Code -	Email		
Home Phone ( ) -	Cell Phone ( ) -	Work Phone ( ) -	
Would you like to receive text messages for appointment reminders? ☐ Yes ☐ No			
What is your preferred contact method from our office? ☐ Home ☐ Cell ☐ Work ☐ Patient Portal			
Primary Language Spoken ☐ English ☐ Other:		Race/Ethnicity	
Marital Status ☐ S ☐ M ☐ D ☐ W ☐ DP			
Primary Care Physician	Phone ( ) -	Last Seen / /	
Pharmacy Name	Location		
Employer	Occupation		
Who is in charge of your medical management? ☐ Self ☐ Other:			
Emergency Contact Name	Relationship	Phone ( ) -	

INSURANCE INFORMATION

Primary Insurance:	☐ Aetna	☐ BCBS	☐ Cigna	☐ Humana	☐ Medicare	☐ Other:
Secondary:	☐ Aetna	☐ BCBS	☐ Cigna	☐ Humana	☐ Medicare	☐ Other:

Member's Name: Member's Date of Birth: / /

If the patient is a minor (17 and under), name of guarantor or responsible party:

HOW DID YOU HEAR ABOUT US? (Please check all that apply)

Internet Search: ☐ Google using key words _____ ☐ Website ☐ Facebook / Social Media

Referral: ☐ Friend/Patient Name _____ ☐ Doctor _____

Local Ad: ☐ Val Pak ☐ Lemont Life

Phone Book: ☐ Home Pages from the town of _____

Church Ad: ☐ St. Al's ☐ St. Cyril's ☐ St. Pat's

Other: ☐ Walk-in / Saw Sign ☐ Insurance Site ☐ Other _____

Providing comprehensive, quality foot care for the entire family.

Allergies

☐ No known allergies

☐ No known drug allergies

I am able to take NSAIDs (Advil, Aleve, Aspirin, ibuprofen)

☐ Yes ☐ No: _____

Allergy / Intolerance	Reaction	Severity
		mild mod severe
		mild mod severe
		mild mod severe
		mild mod severe

Medications

Please list all medications and supplements you are taking, or you may provide a complete separate list.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Past Medical & Surgical History

	Condition	***Diagnosis Year***		***Condition***	***Diagnosis Year***		***Condition***	***Diagnosis Year***
☐	AIDS / HIV		☐	Frostbite		☐	Peripheral Neuropathy	
☐	Anemia		☐	GERD / Acid Reflux		☐	Peripheral Vascular Disease	
☐	Anxiety / Depression		☐	Gout		☐	Polio	
☐	Arthritis		☐	Headache/Migraine		☐	Pulmonary Embolism	
☐	Asthma		☐	Heart Disease		☐	Raynaud's Disease	
☐	Back Pain / Sciatica		☐	Hepatitis A / B / C		☐	Rheumatoid Arthritis	
☐	Bleeding Disorder		☐	Hernia		☐	Seizures / Epilepsy	
☐	Blood Clots / DVT		☐	Hypertension (Blood Pressure)		☐	Stroke / CVA	
☐	Cancer		☐	Kidney Disease		☐	Substance Abuse	
☐	Diabetes - Type 1 / 2		☐	Leg / Foot Ulcers		☐	Thyroid Problems	
☐	Dialysis		☐	Liver Disease		☐	Tuberculosis	
☐	Dyslipidemia (High Cholesterol)		☐	Lung Disease		☐	Varicose Veins	
☐	Environmental allergies		☐	Organ Transplant		☐	Other:	
☐	Fibromyalgia		☐	Osteoporosis		☐	Other:	
☐	Foot Deformity		☐	Pacemaker / Defibrillator		☐	Other:	

	Surgery	***Year***		***Surgery***	***Year***		***Other Surgery***	***Year***
☐	Anesthesia problems		☐	Leg stent / bypass R / L		☐	Cataracts	
☐	Heart bypass / stent		☐	Vein Procedure		☐		
☐	Hip Replacement R / L		☐	Foot/Ankle		☐		
☐	Knee replacement R / L		☐	Foot/Ankle		☐		

Other Medical History

Do you smoke? ☐ Yes ☐ No

If yes: _____ packs per day

Smoke/history of smoking for: _____ years

Alcohol intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Illicit drug use: ☐ None ☐ _____

Special diet: ☐ No ☐ Yes : _____

Activity level at work: ☐ Sitting ☐ Walking ☐ Standing ☐ Driving

Exercise level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Sporting activities: _____

Difficulty walking or climbing stairs? ☐ No ☐ Yes

Are you able to care for yourself? ☐ No ☐ Yes

Legally blind in one or both eyes? ☐ No ☐ Yes

Height: _____

Weight: _____

Shoe size: *Right* _____ *Left* _____

Major medical conditions in your family:

☐ Unknown

☐ Mother: _____

☐ Father: _____

☐ Sibling: _____

☐ Other: _____

Reason For My Visit Today

Please list up to 2 conditions, with #1 being the most important.

1) Reason for my visit: _____ **Location:** _____

Symptoms: _____

How often is this bothering you? _____ **Possible cause:** _____

What makes it feel worse? _____

How long have you had this: _____ days wks mos yrs **Severity**: mild moderate severe. Pain + / 10

Any past treatments: _____

2) Reason for my visit: _____ **Location:** _____

Symptoms: _____

How often is this bothering you? _____ **Possible cause:** _____

What makes it feel worse? _____

How long have you had this: _____ days wks mos yrs **Severity**: mild moderate severe. Pain + / 10

Any past treatments: _____

Review of Systems

Please circle all the symptoms you have had in the past 3 months, otherwise check "None."

General:	Fatigue	Nausea	Vomiting	Fever	Chills	Excessive weight gain / loss	☐ None
Hematologic:	Anemia	Easy bruising	Excessive bleeding				☐ None
Neurologic:	Dizziness	Falls	Imbalance	Loss of sensation	Numbness	Tingling	☐ None
Vascular:	Cold feet	Calf pain	Leg cramps	Swelling of legs/feet	Varicose legs		☐ None
Dermatologic:	Corn / callus	Moles	Ingrown nail	Skin growths / lesions			☐ None
	Sores	Warts	Rash / itching	Toenail abnormalities / changes			
Musculoskeletal:	Back pain	Ankle pain	Foot pain	Toe pain	Difficulty walking		☐ None
	Flat feet	Instability	Intoeing	Stiffness	Weakness		

DIANA EMINI, DPM
MICHELLE KIM, DPM

PATIENT CONSENT & RELEASE FORM

AUTHORIZATION OF PAYMENT TO PHYSICIAN
I hereby assign all insurance benefits payable directly to DM Foot & Ankle Associates for services rendered. I understand I am financially responsible and liable for services rendered, regardless of insurance payment.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)
I acknowledge that I was provided a copy of DM Foot & Ankle Associate's privacy Practices. I have read, or had the opportunity to read if I so chose, and understand this notice.

MEDICAL HISTORY FORM
All medical history I provide each visit is true to the best of my knowledge.

FINANCIAL POLICIES
I have read the office policies and agree to their contents.

PHARMACY
In order to ensure an accurate prescription history, all medications from the past eighteen months will be directly updated to the my medical chart from my preferred pharmacy.

AUTHORIZATION FOR USE OF PHOTOS
On occasion, medical photographs of my condition may be taken in the office. Photos may be used for medical documentation, before and after photos, wounds, surgeries, or other conditions. These photos may be part of the medical record, used in case studies or journals, used in teaching, or used in advertisements. Any identifying name, face, or other information will not be used.

I authorize my photos to be used for:

- ☐ Medical records only
- ☐ Medical records, studies, teaching, and advertising (no identifying information)

I have read and fully understand this form and all of its associated contents. This authorization is valid as of today and will remain in effect while I am a patient of DM Foot & Ankle Associates.

_____	_____	_____
Printed Name of Patient	Signature of Patient / Guardian	Date

DIANA EMINI, DPM
MICHELLE KIM, DPM

DM FOOT & ANKLE ASSOCIATES OFFICE POLICIES

Our office policies are updated yearly in hopes to streamline our patient care and overall office flow.

OUR MISSION STATEMENT

To provide comprehensive, quality foot care for the entire family.

WHIRLPOOL SOAKS FOR OUR NAIL AND CALLUS PATIENTS

- We offer foot soaks to our nail and callus patients as a free, complimentary service.
- We ask that you come 15 minutes PRIOR to your scheduled appointment time to receive your whirlpool soak.
- If you do not come 15 minutes PRIOR to your appointment time, you will not receive a whirlpool soak. We appreciate your understanding in our office's efforts in maintaining our daily patient schedule.
- The nail visit is considered a separate appointment from any other foot issues you may be having.
- Our trained medical nail technicians may aid the physician with nail services rendered during your visit.

SEPARATE APPOINTMENTS REQUIRED FOR EACH SERVICE

- We require a separate appointment timeslot for each service being rendered. This helps our doctors and staff to stay on time.
- If you are having a nail and callus visit, you must make a separate appointment for other foot related issues.

DIABETIC PATIENTS

Per Medicare guidelines, all patients with diabetes require an annual foot examination visit, which is a one-time, separate appointment from your nail visit. During this appointment, a full foot check will be performed and your shoes will be evaluated. We will be unable to order diabetic shoes without a diabetic foot exam visit.

LATE POLICY & MISSED APPOINTMENT FEE

We offer a 15 minute grace period past your appointment time should you be running behind schedule. Please call our office to keep you on the schedule. After greater than 15 minutes, or without a phone call, your appointment may need to be rescheduled.

There is a $35 fee for all missed appointments unless a 24 hour notice is given by notifying our office. We all occasionally run late or miss an appointment due to a special circumstance. However, repeated offenses may result in not being able to reschedule your appointment.

CELL PHONE POLICY

Cell phones must be silenced and put away while you are receiving treatment in the office.

MINORS IN THE OFFICE

Patients ages 17 or younger must be accompanied by their parent or guardian. Patients ages 16 and older can be seen without a parent or guardian with the written consent form filled out by the parent or guardian for special circumstances. Children may accompany you during your office visit. However, children ages 11 and under cannot be left unattended in the waiting room.

OFFICE ETIQUETTE

We strive to treat our patients with kindness and respect, and we ask the same courtesy from our patients in return. Patients who exhibit loud or aggressive behavior, such as yelling or profanity, will not be tolerated and may result in being discharged from the practice.

FORMS FEE

There is a $25 fee to fill out any forms.

FINANCIAL POLICIES

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our office managers.

FORMS OF PAYMENT
We accept credit cards including Visa, MasterCard, Discover, and American Express. We accept cash, checks, and Care Credit.

COPAYS
All co-pays are due at time of service.

DEDUCTIBLES
If your health insurance plan has a deductible which has not been met, we may ask for a partial payment for your treatment at the time of service.

COINSURANCE
If your health insurance plan has a co-insurance, you are responsible for all balances due. A co-insurance is a percentage that you must pay for services rendered.

SELF PAY SERVICES
Services that are not billable to your insurance are due at time of service. This includes laser for toenail fungus, retail goods, self-pay patients, Keryflex treatment, and other non-billable services.

ACCOUNT BALANCES
Any balance on your account is due at time of service. If you are unable to pay your balance in full, a credit card can be placed on file and a payment plan can be set up for you. If your account balance remains unpaid for greater than 90 days, you will be asked to pay a minimum of 50% of your outstanding balance in order to make any future appointments.

RETURNED CHECK FEE
There is a service fee of $25 for all returned checks.

COLLECTIONS
Unpaid balances may be subject to collections. If you are having financial difficulty, a payment plan can be set up for you to avoid being sent to collections.

OUTSIDE VENDORS
On occasion, an order will be sent to an outside vendor for lab work or medical supplies. All billing for these services is handled by the outside vendors and all billing questions should be directed towards them.

TO ALL PATIENTS USING HEALTH INSURANCE
Healthcare and health insurance plans are constantly changing and being updated on a regular basis. It is up to you to know and understand your healthcare benefits.

We offer a courtesy insurance verification for our patients. This information can let us know if there is any co-pay or deductible and gives us a general understanding of your insurance coverage. This information is subject to change.

UNDERSTANDING MEDICARE INSURANCE
Medicare Part B is accepted in this office. Medicare Part B will pay for 80% of the contracted billing charges. The remaining balance of 20% is your responsibility. If you have a secondary insurance, it will be automatically billed after Medicare processes the claim. Each secondary insurance is very different. Some secondary insurances require a co-payment. Others do not cover the 20% remaining balance in full and the balance becomes your responsibility.

Did you know that Medicare has a deductible? In 2019, the Medicare Part B deductible is $185.00. While some secondary policies will cover a portion of this deductible, many secondary policies do not and hold you responsible for any balance.

All patients with Medicare insurance must sign an Advance Beneficiary Notice (ABN) for Durable Medical Equipment and other services rendered.

PLEASE TAKE NOTE:

DM Foot & Ankle Associates is a SPECIALIST office (not a primary care physician office). All visits with the physician are billed with an OFFICE VISIT code, which includes your examination and treatment plan discussion with the doctor.

X-rays are considered a separate, billable service code.

Other procedures are also considered separate from the office visit and a separate billing charge. This is including but not limited to: injections, in-office minor surgeries, biopsies, application of casts, arch supports, orthotics, and durable medical equipment such as walker boots, night splints, or ankle braces.

OTHER POLICIES REGARDING YOUR HEALTH INSURANCE

- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay, co-insurance, and deductible at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- All visits with the physician or medical assistant will be billed to your insurance.
- As our patient, you are responsible for all referrals needed to seek treatment in this office.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- If you are seen as an inpatient in the hospital, the visits will be billed to your insurance. Any balance due is your responsibility.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- Phone and or email consultations may be billed to your insurance.