WEIL FOOT & ANKLE INSTITUTE

(Please Print)

REGISTRATION FORM

Today's Date _____/_____/_____ Facility __________________________ Doctor ____________________

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Mrs. ☐ Dr. ☐ Miss	☐ Sr. ☐ Jr.

Street Address	City	State	Zip Code

Home Phone #	Work Phone #	E-mail Address
( ) -	( ) -	

Birth Date	Age	Social Security Number	Marital Status	Sex
/ /			☐Single ☐Mar ☐Widow ☐Div	☐ M ☐ F

INSURANCE INFORMATION

Occupation	Insured Employer

Insured Employer Address

Please indicate primary insurance	Address of primary insurance carrier	Phone number
		( ) -

Insured Name	Insured S. S. #	Insured ID	Policy Group #	Eff. Date	Co-Payment
					$

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other **Insured Birth Date** /   /

Insurance Type ☐ PPO ☐ EPO ☐ HMO ☐ POS ☐ Self Pay ☐ Medicare ☐ Public Aid ☐ WC ☐ OTHER _______________.

Please indicate secondary insurance	Address of secondary insurance carrier	Phone number
		( ) -

Insured Name	Insured S. S. #	Insured ID	Policy Group #	Eff. Date	Co-Payment
					$

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other **Insured Birth Date** /   /

Insurance Type ☐ PPO ☐ EPO ☐ HMO ☐ POS ☐ Self Pay ☐ Medicare ☐ Public Aid ☐ WC ☐ OTHER _______________.

Referred to Institute by (Please use one) **Address**

☐ Doctor ____________________ ____________________

☐ Hospital ____________________ ____________________

☐ Insurance Plan ____________________ ____________________

☐ Family ____________________ ____________________

☐ Friend ____________________ ____________________

☐ Tribune ☐ Herald ☐ Sun Times ☐ T.V. ☐ Radio

☐ Other ____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
To Weil Foot & Ankle Institute, Ltd.

X ______________________________ /   /
Signature Date

HIPPA AUTHORIZATION
Necessary to process claims

X ______________________________ /   /
Signature Date

MEDICAL HISTORY

PATIENT NAME	**BIRTH DATE**	/ /

ALLERGIES (LIST KNOWN ALLERGIES OR REACTIONS TO DRUGS/MEDICATIONS)

☐ Penicillin	☐ Sulfa	☐ Local Anesthetic	☐ Anti-inflammatory Medication
☐ Codeine	☐ Tape	☐ Nausea From Anesthetic	☐ Iodine on Skin

MEDICATIONS *(PLEASE LIST CURRENT MEDICATIONS THAT YOU ARE TAKING: PRESCRIPTION AND OVER THE COUNTER)*

MEDICATION	DOSE	MEDICATION	DOSE

FOOT/ANKLE PAIN WHERE?	**HOW LONG?**	MONTHS	YEARS

WHAT PREVIOUS TREATMENT HAVE YOU HAD ON YOUR FOOT/ANKLE?

☐ Surgery	☐ Orthotics	☐ Oral Medications	☐ Cortisone Shots

FAMILY PHYSICIAN INFORMATION

Medical Doctors Name	Phone Number ( ) -

Street Address	City	State	Zip Code

Have you ever been put to sleep for surgery? ☐ **Yes** ☐ **No**

SHOE SIZE	**HEIGHT**		**WEIGHT**
DO YOU DRINK?	☐ NO	☐ YES	DRINKS PER WEEK
DO YOU SMOKE?	☐ NO	☐ YES	PACK(S)/DAY

Indicate which of the following you have had or have at present. Check Yes or No to each item

Arthritis/Rheumatism	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Artificial Joints (hip, knee, etc.)	☐ Yes	☐ No	H.I.V. Positive	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	Motion Sickness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Neurological Disorder	☐ Yes	☐ No
Heart (Surgery, Disease, Attack)	☐ Yes	☐ No	Psychiatric/Psychological Care	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Stomach Problems / Reflux / Heartburn	☐ Yes	☐ No
Hepatitis A (Infectious) B (serum)	☐ Yes	☐ No	Ulcers (Diabetic)	☐ Yes	☐ No

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

X	/ /
Patient/Guardian Signature	Date

HISTORY REVIEWED BY: DR. SIGNATURE DATE

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PATIENT INFORMATION

Patient's Last Name	First	Middle	Birth Date
			/ /

DEMOGRAPHICS (FOR GOVERNMENTAL STATISTICAL ANALYSIS)

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Black or African American ☐ White ☐ Hispanic ☐ Other Pacific Islander ☐ Other Race ☐ I Decline to Report

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ I Decline to Report

Preferred Language ☐ English ☐ Spanish ☐ Other ____________________________

PHARMACY / PRESCRIPTION INFORMATION

Preferred Pharmacy:

☐ Costco ☐ CVS ☐ Osco ☐ Target ☐ Wal-Mart ☐ Walgreens ☐ Other ____________________________

Address or Cross-Streets: ____________________________

City: ____________________________

State: __

Zip Code: ____________________________

Phone Number: ____________________________

Fax Number: ____________________________

☐ This is a mailorder pharmacy

☐ I do not have a preferred pharmacy

I authorize Weil Foot & Ankle Institute and its affiliated providers to view my external prescription history via the Surescripts service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

To Weil Foot & Ankle Institute, Ltd.

X ____ / /

Signature Date

WEIL FOOT & ANKLE INSTITUTE

FINANCIAL POLICY

Thank you for choosing Weil Foot & Ankle Institute as your health care provider. We are committed to the successful treatment of your condition. Please understand that payment of your bill is considered part of your treatment. Should you have any questions regarding any aspect of your financial status with our office, please feel free to contact our billing department at (847) 627-4920.
Your clear understanding of our Financial Policy is important to our professional relationship.

- WE ARE HAPPY TO BILL YOUR INSURANCE DIRECTLY; HOWEVER, WE MUST HAVE A COPY OF THE INSURANCE CARD
- IF YOU DO NOT HAVE YOUR INSURANCE CARD WITH YOU, FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA/MASTERCARD, AMERICAN EXPRESS, DISCOVE AND CARECREDIT.
- ALL PATIENTS MUST COMPLETE OUR "PATIENT REGISTRATION FORM" AND OTHER RELATED FORMS.
- PLEASE, NOTIFY US IMMEDIATELY OF ANY CHANGES IN YOUR INSURANCE OR COVERAGE.
- 5 BUSINESS DAYS NOTICE IS REQUIRED FOR COPIES OF MEDICAL RECORDS OR X-RAYS AND THERE MAY BE A NOMINAL FEE.

Self Pay

We expect payment at the time of service unless prior arrangements have been made

Medicare

We accept Medicare assignment. As a Medicare patient, you are responsible only for the deductible if you have supplemental insurance. A few services and supplies are not covered by Medicare we will advise you of any non covered charge prior to the service being provided.

HMO/PPO

ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. IF YOU DO NOT KNOW YOUR CO-PAY, YOU MAY USE OUR PHONE TO FIND OUT. We are members of most, but not all plans. You are responsible for verifying that we are providers for your plan. If you are an HMO member, you will not be billed as long as we have the necessary referrals. Please note: You must have your referral at the time of the visit or your plan requires that we ask you to reschedule. PPO patients will only be responsible for their deductible, co-payments and co-insurance, as long as they have verified with their insurance that our physician is in their plan.

Workers' Compensation

If you are here because of a work related injury, we will require information regarding both health insurance and your employer's Workers' Compensation insurance. Before seeing a doctor, we will require a letter or statement from the Workers' Compensation carrier authorizing your treatment. The letter should include the claim number, address, adjuster's name and phone number. (Your employer's human resources office should be able to assist you with obtaining this information.) If payment is not received from these third parties within 90 days, we have the right to bill you directly.

Hospital and Surgery Center Charges

In the event that you undergo surgery in a hospital or ambulatory surgery center, a separate charge will be made by that facility. Your podiatric physician at the Weil Foot & Ankle Institute may have a financial interest in a surgery center where you will be having your surgery.

MRI Charges

The MRI located at this facility is owned by the Weil Foot & Ankle Institute. If your podiatric physician orders an MRI you have the right to choose another facility to perform your MRI.

Financial Agreement

I understand that I am financially responsible for all charges not covered by insurance and I guarantee the balance to be paid by my credit card, check or cash. Past due balances may be subject to additional fees.

UCR (Usual and Customary Rates)

We are committed to provide the best treatment possible for our patients and we charge what is usual and customary for our area. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance company's arbitrary determinations of UCR rates.

I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed to ensure payment for services rendered to me. I understand that I am ultimately responsible for payment for all services.
If payment is not received from the insurance carrier or other responsible party in 90 days, I will be billed directly.
I will pay unpaid balance by: ____Cash ______Check ______Credit Card ____ CareCredit

_______________________ _______________________ ________

Name of Patient (please print) | Signature of Patient or Responsible Party | Date

AUTHORIZATION AGREEMENT FOR PAYMENT OF YOUR BILL

This authorization is for the patient responsibility portion of your bill. For contracted insurance, this will be the amount remaining after insurance payment and adjustment by your insurance company.
We acknowledge that the origination of transactions to your account must comply with the provisions of U.S. law.

Patient Name____**Pt. Acct #**______________
(Please Print)

Cardholder's Name ____
(If different from patient)

Credit Card #____
LAST 4 DIGITS IN CODE

Expiration Date___________ **Security Code**_______________
Mo/Yr **DIGITS IN CODE**

(Circle one) Master Card Visa American Express Discover CareCredit

I authorize Weil Foot & Ankle Institute to keep my signature on file and to charge the credit card identified above for the balance of charges not paid by my insurance company 60 days or more following date of service. This is for all treatment provided for the above named patient.

Patients that are scheduled to see Dr Lowell Weil Sr., Dr Lowell Weil Jr., or Dr David O'Brian must leave a credit card on file or leave a cash payment of $150.00 prior to seeing the doctor.

***No credit card charge will be made until 60 days or more following date of service.**

I will be notified by billing staff or statement of any charges made to my credit card.

At any time, I may elect to pay my account in full to prevent this authorization from being activated.

I assign my insurance benefits to Weil Foot & Ankle Institute. I understand that this form is valid unless I cancel the authorization through written notice to Weil Foot & Ankle Institute.

____
CARDHOLDER SIGNATURE (If different from patient) DATE

____
PATIENT SIGNATURE (parent signature if under 18) DATE

WEIL FOOT &ANKLE INSTITUTE 1455 GOLF RD DES PLAINES, IL 60016