LINCOLN PARK PODIATRY
Debra E. Young, DPM
2752 N Southport, Chicago 60614
773-327-0006

PATIENT INFORMATION FORM

PLEASE PRINT

Date: _____

□Male □ Female
Patient's Name: _____ Date of Birth:_____
Age:___

Parent or Guardian (if a minor)_____

Address: _____ Apt: ____ City: _____ State: ____ Zip: _ _ _ _ _

Home Phone:_____ Work Phone:_____ Cell phone:_____

Messages including Personal Health Information may be left at: □ Home □ Cell □ Work □ Email

Social Sec. #: _____ Email: _____ Employer: _____

Primary Language: _____ Race: _____ Ethnicity:_____

Emergency Contact: _____ Phone:_____ Relationship:_____

MEDICAL HISTORY

Reason for seeing doctor today:
_____
Previous foot, ankle or leg problems/injury/surgery:_____

List any other operations and dates:_____

Height: ____ft ____inches Weight: _____lbs Blood Pressure (Office Use): _____ / _____ / _____

Shoe size: _____ Have You Received Your Flu Shot This Year? _____

Have you or your family ever had or been treated for the following?

You|Family	You|Family	You|Family	You|Family
□ □ Heart Attack	□ □Diabetes	□ □Asthma	□ □ Kidney problems
□ □ Gout	□ □ Stents in legs	□ □Pneumonia	□ □ Stomach ulcers/reflux
□ □ AIDS or related Complex	□ □Poor Circulation □ □ Blood Clots	□ □ Varicose veins	□ □ Peripheral Neuropathy in Feet/Legs
□ □ High Blood Pressure		□ □ Heart Problems	□ □ Arthritis
□ □ Knee/ankle injury	□ □ Foot injury	□ □ Back injury	□ □ Herniated Disc
□ □ Alcoholism	□ □ Bleeding Tendency		□ □ Thyroid Disorder

Do you wear orthotics? _____ Anything else Dr. Young should be aware of? _____

CURRENT MEDICATIONS:

_____

ALLERGIES:

□None □Penicillin □Codeine □Cortisone □Anesthetics □Vicodin □Demerol □Aspirin □Iodine
Other:_____

Do you smoke? □Never □No □Yes ____packs/day # years smoked _____

Occupation/job?_____ Hours/day on your feet at work?_____

What are your other frequent activities requiring your feet? □Sports □Exercise □Walking □Travel □Work

Primary Care Physician _____Date Last Seen:_____
Address:_____
Phone:_____

REFERRED BY / HOW HEARD?
□Doctor _____Address _____City _____ZIP_____
□Patient/Friend (name) _____
□PPO Insurance Directory □Physician's Referral Service (St. Joseph's) □Yellow Pages/Dex □ Walk by/Sign
□Angie's List □Internet Search (please specify): □Google □Yahoo □Facebook □Bing □Other: _____
□Advertisement (please specify) _____ □Promotional Offer (please specify)_____
□Met Dr. Young at (specify) _____ □Other _____

PERMISSION TO TREAT: I hereby give permission to Dr. Young to examine, to photograph, to administer treatment andto perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot problem.

Signature (patient or guardian): _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I have read (or had theopportunity to read if I so choose) and understood the notice. I understand that a paper copy will be provided to me if I request one.

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION: I authorize **Debra E. Young, DPM, PC** to release any information regarding the medical history and treatment including disability related information to any third party payer (including Medicare), or their contracted agents, to validate or determine benefits payable for services rendered to myself or any dependents.

Signature: _____ Date: _____

Financial Policy / Assignment of Benefits & Payments

It is always good policy to understand and agree with the financial policy of an office. We appreciate having you as our patient and strive to provide you with the best care possible. Misunderstandings regarding insurance coverage and financial policy make it uncomfortable for everyone. If you ever have any questions or wish to discuss your account with us, please do not hesitate. Your signature indicates your understanding and agreement to the following policies:

Assignment of Benefits and Payments
I authorize payment for services rendered to me or my dependents to be paid directly to Debra E Young, DPM, PC, from my insurance company, my attorney, or any other party who may become obligated to pay Dr. Young any sums. I further authorize the endorsement of my name to any draft containing my name to which Dr. Young is legally entitled.

Pre-authorization by your insurance company:
If my insurance plan requires a pre-authorization from my primary physician, I, as the insured party, am responsible for obtaining the pre-certification number prior to my appointment. If this has not been done, I will be asked to pay for my visit or will be asked to reschedule my appointment until this required information is obtained. Of course, I have a right to pay for medical services that are not determined to be coverable by my insurance company.

In-Network:
I realize I am responsible for determining if Dr. Young is in-network with my insurance plan. I have called or gone online to see if Dr. Young is in-network. If Dr. Young is not in-network, I am responsible for out of network benefits or un-covered fees.

Referrals:
If my insurance plan is an HMO and/or requires a referral to see Dr. Young, I realize I am responsible in obtaining the referral from my primary care physician. If service is given without referral, I realize I am responsible for the fee.

Financial Responsibility
Commercial insurance is filed as a courtesy to the patient, and managed care insurance is filed with the contracted carrier. I understand that I will be held financially responsible for any balances incurred in this office as well as for any charges that are not paid by my insurance company, including, but not limited to, co-pays, deductibles, co-insurance and services or charges not paid by insurance for any reason, after consideration of contractual adjustments.

Balances unpaid 90 days after services are rendered will be considered delinquent and become my responsibility. A late payment charge of **1 ½ percent per month** will be added to my account if a payment is not made within 90 days. The late payment charge will be billed each month until those charges are paid **(at the rate of 18 percent per year)** and will appear separately on my regular statement.

Outstanding Balance:
In the event that my account goes into default and your office turns it over to an outside collections agency/attorney for collections, it is accepted and agreed that thirty percent (30%) of the principal amount of
the balance due will be added as collection/attorney fees. It is also agreed and accepted that in the event that a lawsuit is filed, I will be liable for any and all court costs expended whether judgment has been entered or not.

Non-sufficient funds or closed accounts:
For this, there will be a **$30.00 service charge**. I realize that your bank charges you for my NSF check and my bank will charge you for the check as well. I will let you know if I need to make payments over time. I understand that your office will definitely make arrangements with me.

Missed appointment charges:
Missed appointments mean that not only were my feet not treated but someone else could have been seen and helped. If I fail to cancel an appointment at least 24 hours prior to my appointment, or if I miss the appointment completely, I **understand there will be a $75.00 charge**. I understand the payment for this charge will be collected at the time of my next appointment, unless I pay the amount beforehand.

Returned products:
I understand that insoles and other products may be returned within 1 week for refund providing they are in “as-new” condition. That means the insoles have not been worn and the products have not been opened
and used at all. They must be able to be given to other patients. Custom insoles, orthotics and braces are not refundable. Adjustments are included providing I am a current ongoing patient.

_____ _____
Signature Date