Welcome to Midwest Podiatry Centers
Our mission is to improve the health of our patients and the community.

We appreciate the confidence you have shown in choosing us for your medical care. The following are a few tips to help ensure that your visit is as smooth as possible.

Check In Requirements

- On the day of your appointment, please arrive 15 minutes early to fill out paperwork and bring the following:
- Current identification (Driver's License or State ID)
- Current insurance card(s)
- Current list of medications you're taking
- You will be required to pay any copays and any outstanding balances at check in
- A map of our locations can be found on our website at www.midwestpodiatrycenters.com

Understanding Your Benefits

- Know what your health plan covers. You'll find your benefit information in your plan documents or on the health plan's website.
- Know if your plan has a provider network and if Midwest Podiatry Centers is participating in your network; a clinic's acceptance of your insurance card is not a guarantee that your plan covers care at this clinic.
- If you are unsure of your benefits for the clinic you've selected, you can contact your health plan at the phone number on the back of your insurance card.

Payment Responsibility & Payment Methods

- Midwest Podiatry Centers files insurance claims for patients as a courtesy with the understanding that the patient/guarantor has full responsibility for payment of the bill.
- We offer the flexibility of a personal check, cash, money orders and all major credit cards.
- Payment arrangements within our guidelines can be made by contacting our Billing Department. If your account is not paid in accordance with our guidelines, it is subject to review for placement with our collection agency or further legal action.

Our professional customer service center will assist you with any questions concerning your account. For help with billing questions call (612) 788-8778 and press 2

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CONFIDENTIAL INFORMATION ***(Please print)***

About the Patient

First Name:_____ **Middle Initial:**_____ **Last Name:**_____
Address:_____
City: _____ **State:** _____ **Zip:**_____
Phone (home): _____ _____**Cell :**_____
Email:_____

Date of Birth: _____ **Age:** _____ **Sex:** ◯ **M** ◯ **F**
Primary Language: _____**Ethnicity:**_____

In case of emergency, who should be notified: _____

Relationship to patient: _____**Phone:** _____

Name of Primary Care Physician/Referring Physician: _____ _____

Date Last Seen: _____ **SSN** _____

Primary Care/Referring Physician Address: _____

Pharmacy Name and Phone Number: _____

How did you hear about us? ◯ Relative/friend ◯ Insurance provider ◯ Internet search ◯ Doctor ◯ Facebook

◯ Clinic Mailing ◯ Website ◯ Other_____

Insurance Information

Please give your insurance card to receptionist to make a copy

Family History (please mark each that apply)

Diabetes:_____ **Heart Disease:**_____ **Cancer:**_____

Arthritis:_____ **Kidney Disease:**_____ **Peripheral Vascular Disease**_____

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Medical History

Have you been ever been hospitalized for surgery or illness: ◯ Yes ◯ No

If within past five years, please list when, and for what reason(s):

_____

_____

Please list any medications you are presently taking: _____

_____

Allergic to any Medications: Yes/No **List any allergies to medications:** _____

Do you smoke: Yes/No/Former **If so, how many packs a week**_____ **When did you quit**_____

Do you Drink alcohol: Yes/No **How much**_____ **How often**_____

Received Yearly Flu shot Yes/No

Have you ever had any of the following? Please circle all that apply:

Anemia	Glaucoma	Rheumatic fever
Arthritis	Gout	Excessive scarring
Asthma	Joint replacement	Stroke
Blood transfusion	Heart disease	Tumors
Blood clots	Serious infections	Difficulty in healing
Cancer	Hepatitis	Ulcers
Diabetes (A1C_____)	Liver disease	HIV positive
Drug addiction	Neuropathy	High blood pressure
Epilepsy	Kidney disease	Other: _____
Edema	Poor circulation	

Today's Visit

What is your foot complaint today: _____

Location of your problem (be specific):_____

Length of time you have had this problem:_____

How did it occur? _____ Injury _____ Gradual onset _____ Rapid onset _____ Pain off and on

Describe your pain:

___ Burning ___ Aching ___ Throbbing ___ Sharp ___ Stabbing ___ Shooting ___ Numbness

What would you rate your pain, with 10 being severe pain?

0 1 2 3 4 5 6 7 8 9 10

What makes the pain worse?_____

What makes it better?_____

What have you tried to treat the condition?_____

Have you seen anyone else for this condition?_____

FINANCIAL POLICY

Thank you for choosing **Midwest Podiatry Centers.** We are committed to your treatment being successful. The following is a statement of our Financial Policy.

If you have an insurance plan with a carrier with whom we are contracted to provide services, we will submit an electronic claim to your carrier for services rendered. You will be responsible for any coinsurance and deductible amounts due. Please check with your insurance carrier to see if you will need a "referral" from your primary care provider before you are seen. Copayments are due and collected at the time of your appointment.

All insurance balances must be paid within 30 days of treatment unless payment arrangements are made. If you cannot afford to pay the full amount due please contact the business office to set up a payment plan. If a balance owed goes over 90 days past due and no approved payments have posted to the account, it will be forwarded to a collection agency. The balance along with collection costs (25% of balanced owed) will be sent to a collection agency for further action and you will be responsible for all collection fees, return check fees and legal fees if litigation is necessary.

Medicare patients are required to meet a deductible each year starting in January for any medical services. If you have a supplemental or secondary insurance please present the card at the time of your visit and we will submit a claim for your services after your primary insurance has processed. Medicare patients may also be asked to sign an Advance Beneficiary Notice per Medicare guidelines for all services deemed to be a non-covered service.

Please let us know if you have any questions or concerns. I have read the Financial Policy and have received/been offered a copy of this policy for my records. I am accepting financial responsibility as explained above for all payment of services/products received.

Name of Patient (print): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices. This includes the situation where your first date of service occurred electronically.

I have received a copy or been offered a copy of privacy notice that applies to Midwest Podiatry Centers.

_____ _____

Print Patient Name **(DOB)**

_____ _____

Patient's Signature or Personal Representative's Signature **Date**

_____

If Personal Representative, describe relationship

For Office Use Only
Staff should complete if Acknowledgement Form is not signed

Does patient have a copy of the Privacy Notice? [ ] Yes [ ] No

If you answered "No" above, please explain why the patient did not sign an acknowledgement form.

[ ] Patient *Unable* to Comprehend
[ ] Patient Communication Barrier
[ ] Legal Representative not Available

Completed by: _____