



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



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

Swift Ad Radio Ad KS95 Clinic Mailing MPC Website Valpak 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 _____

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.

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.

No-Show Policy: A \$75.00 charge may be applied for missed appointments or cancellations within 24 hour notice. Exceptions may be made based on extenuating circumstances. If you require interpreter services at your missed appointment, associated costs not covered by your insurance may be your responsibility.

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**

_____ **Date of Birth**

_____ **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: _____