WISCONSIN FOOT CENTER, LLC
step forward

6130 S. 108th Street
Hales Corners, WI 53130
414-425-8400

PATIENT INFORMATION FORM

(**PLEASE PRINT**)

Date: _____ **Patient Name:** _____

Date of Birth: _____ **Age:** _____ ☐ **Male** ☐ **Female** **Marital status:** **married** **divorced** **single**

Parent or guardian (If a minor): _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Email: _____

Primary Phone #: _____ **Work #** _____ **Cell Phone #:** _____

S.S. #: _____ - _____ - _____ **Employer:** _____

Primary Language: _____ **Race:** _____ **Ethnicity:** **Hispanic** **Non-Hispanic** **Asian**

Emergency contact: _____ Relationship: _____ Phone# _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Insured Name: _____ Insured D.O.B.: _____ Relationship to insured _____

Policy #: _____ Group # _____

Secondary Insurance Company: _____

Insured Name: _____ Insured D.O.B. _____ Relationship to insured _____

Policy #: _____ Group # _____

CONSENTS

☐ **Permission to treat** I authorize Dr. Andrew J. Marso to perform such general procedures as he may deem necessary in the diagnosis and/or treatment of my foot condition. I further authorize the release of medical information for insurance purposes and request that payment of benefits be made directly to the doctor. I understand that any remaining balance will be my responsibility.

☐ **Authorization to release information:** I authorize Dr. Andrew J. Marso, DPM 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.

☐ **Acknowledgement of receipt of notice of privacy practices:** I acknowledge that I have read or (had the opportunity to read it if I so choose) and understood the privacy notice. I understand that a paper copy will be provided to me if I request one.

☐ **Permission to E-mail/Text**: I give Wisconsin Foot Center and staff permission to correspond with me via email/ text for purpose of appointment confirmation, changes to appointment, informational e-mails and conveying general information. I understand that e-mail is not a secure form of communication, and that confidentiality of any e-mail information cannot be ensured. Our office may forward e-mails internally to those involved, as necessary, for healthcare operations and other handling. Our staff will not forward e-mails to independent third parties without patients' prior written consent, except as authorized or required by law.

Please be advised that e-mail is not to be used to communicate urgent matters or emergencies.

Responses to e-mails will be given within 1-2 business days, excluding holidays.

►► Patient or guardian Signature: _____ **DATE:** _____

MEDICAL HISTORY

Reason for your visit today: _____

Previous foot, ankle, or leg problem: _____

_____

Do you wear an insert or device in your shoe? □ **No** □ **Yes** (Be specific): _____

List any foot or ankle surgery: _____**Year**_____

Height: _____ **feet** _____**inches** **Weight:** _____**Lbs.** **Shoe size:** _____ Width_____

Have you been treated for any of the following? (Please circle)

Arthritis	**Diabetes**	**Anemia**	**Raynaud's disease**
Kidney Disease	**Prolonged Bleeding**	**Circulatory /Vascular Disease**	**Varicose Veins**
High Blood Pressure	**Foot Fracture**	**Liver Disease**	**Rheumatoid Arthritis**
Stomach ulcer	**Asthma**	**Depression/Anxiety**	**Cancer** _____
HIV/AIDS	**Hepatitis A B C**	**Difficulty Healing**	**Heart Problem**_____

Other _____

Family physician: _____**Phone#**_____

Referred by: _____

Have you seen a Podiatrist before? (If yes, name of the podiatrist) _____

Pharmacy: _____Address _____Phone #_____

Current medications (DO NOT SKIP THIS SECTION) ☐ LIST PROVIDED ☐ NOT CURRENTLY TAKING MEDICATIONS

1. _____ **2.** _____ **3.** _____

4. _____ **5.** _____ **6.** _____

7. _____ **8.** _____ **9.** _____

DO YOU HAVE ANY ALLERGIES: □ Yes □ No

☐ Penicillin ☐ Codeine ☐ Cortisone ☐ Anesthetics ☐ Aspirin ☐Vicodin ☐ Iodine ☐ latex ☐ antibiotic _____

☐ Sulfa drugs OTHER: _____

DO YOU SMOKE? ☐ Yes ☐ No ☐ Former packs/Day_____ How many years? _____

►►Patient or guardian Signature: _____**DATE:** _____

WISCONSIN FOOT CENTER PAYMENT POLICY

Insurance: For your convenience, we participate in most insurance plans, including Medicare. If you are not insured by a plan we are contracted with, payment in full is expected at each visit. If you are insured by a plan that we are contracted with but don't have a Current insurance card, payment is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and Deductibles: **All co-payments and deductibles must be paid at the time of service.** This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

Non-covered services: Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You will be required to pay for these services in full at the time of the visit.

Proof of Insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide a proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claim Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may request medical records. Please be aware that the balance of your claim is your responsibility. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. All balances are due upon receipt of a statement. In certain circumstances, a 90- day payment arrangement can be made.

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment: Balances 60 days past due must be paid before receiving further treatment. If your account balance is over 90 days past due, you will receive a letter stating that you have 14 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Further services will not be rendered until complete payment of account is received. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

CANCELLATION AND NO-SHOW POLICY

Cancellations: We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all of our patients. In return, we ask that patients make every effort not to change reserved appointments. When appointments are missed or little notice is given, other patients who need appointments have to wait. We require a 24- hour notice. Office appointments which are cancelled with less than 24- hour notification will be subject to a $25.00 cancellation fee.

Cancellations for surgical procedures, require 5-7 business day advance notice, without notification they may be subject to a $ 150.00 cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure will be considered a no show. Patients with no show 3 or more times in a 12- month period, may be dismissed from the practice and will be denied any future appointments.

☐ I have read and understand the payment and no-show policy and agree to abide by its guidelines.

Signature of Patient or Legal Guardian Date