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: _______________
Primary Care/Referring Physician Address: _________________________________________________________
Pharmacy Name and Phone Number: _____________________________________________________________
How did you hear about us? ○ Relative/friend ○ Insurance provider ○ Internet search ○ Doctor ○ Yellow Pages
○ Social Media ○ Website ○ Other_____________________________________________

Insurance Information

Primary Insurance Carrier: ________________________________________________________________
Secondary Insurance Carrier: ___________________________________________________________
Policy Holder Name: _____________________________________________________________________
Relationship to patient: ____________________________  DOB: ______________________________
Address if different from patient: ____________________________________________________________
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______)
Drug addiction  Liver disease  HIV positive
Epilepsy  Neuropathy  High blood pressure
Edema  Kidney disease  Other: _____

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?
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: ___________________________________________________________