Fox River Foot and Ankle Centers, P.C.

810 E. Division, Coal City, IL 60416 815-634-2324
2081 S. Ridge Rd., Ste 113, Minooka, IL 60447 815-521-9347
3963 US Highway 34, Oswego, Il 60543 630-551-3338

FOX FOOT AND ANKLE.COM
PODIATRY
H. CRAIG FOX, DPM

PATIENT INFORMATION

Thank you for selecting Fox River Foot and Ankle Centers, P.C.. Dr. Fox and staff will strive to provide you with the best podiatric care. To help us meet this goal, please fill out this form. If you need any assistance, please ask us - we will be happy to help.

Please print and fill out in full. Thank you!

Today's Date:_____
Is this patient a minor? ❑Yes ❑No If yes, please fill out parents information.
Patient's Last Name:_____First Name:_____Middle:_____
Birth Date:_____Age:_____Sex: ❑M ❑F
Marital Status : ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed
Street Address:_____
P.O. Box:_____City:_____State:_____Zip Code:_____
Home Phone Number: _____Cell Phone Number:_____
Work Phone Number:_____Email address:_____
Preferred method of communication: ❑Email ❑ U.S. Mail ❑Phone ❑Cell Phone
Occupation:_____
Employer:_____
Primary Care Physician:_____
Primary Care Physician Address:_____
Primary Care Physician Phone Number:_____Date Last Seen:_____
Pharmacy of Choice:_____Patient Shoe Size:_____
Other family Members Seen Here:_____
Preferred Language:_____
Ethnicity: ❑Non-Hispanic ❑Hispanic ❑Not Specific
Race: ❑African or African American ❑Asian or Asian American ❑Caucasian or European American
❑Native American or Native Alaskan ❑Native Hawaiian or Other Pacific Islander ❑Other Race

Spouse Information
Is this person a patient here? ❑Yes ❑ No
Spouse Name:_____Spouse Birthdate:_____
Spouse Phone Number (if different):_____
Spouse Address (if Different):_____
Spouse Occupation:_____Spouse Employer:_____
Spouse Employer Address:_____

Patient's Parent Information (if minor or applicable)

Mother' s Info:

Name:_____Birth Date:_____Home Phone #:_____
Address (if different)_____
Occupation:_____Employer:_____
Employer Address:_____Employer Phone #:_____
Patient Here? ❑Yes ❑No

Father's Info:

Name:_____Birth Date:_____Home Phone #:_____
Address (if different)_____
Occupation:_____Employer:_____
Employer Address:_____Employer Phone #:_____
Patient Here? ❑Yes ❑No

Whom may we thank for your referral? Please check one:
❑Doctor _____❑ Family/Friend_____ ❑ Insurance Company
❑Office Sign ❑Close to Work/Home ❑Yellow Pages ❑Newspaper ❑Internet

INSURANCE INFORMATION

Please give your insurance card to the receptionist to be scanned into your record. If you are not the primary insurance holder, please provide Insurance Holders Full Name _____
and Date of Birth_____

Please note: in cases of divorce, the undersigned agrees that any amount remaining unpaid after insurance will be the responsibility of the parent who brings the child in for his/her appointments.

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):_____
Relationship to patient:_____
Home Phone Number:_____Work Phone Number:_____

About Your Medical History

Height:_____Weight:_____Smoker? ❑Yes ❑No If Yes, Amount Per Day_____
Diabetic? ❑Yes ❑No If Yes, Contolled By: ❑Insulin ❑Medication ❑Diet
Do you have any allergies to any medications? _____
_____
If so, what was the reaction: ❑Rash ❑GI Upset ❑Other (explain)_____
Current Medications:_____
_____
Any medical problems that you are being treated for, other than the podiatric issues you are here for today?_____
_____
_____
Have you had any surgery of any kind in the past?_____
_____

Dr. Fox will make every effort to explain your diagnosis and treatment options to you.
If for any reason you do not understand something, please stop the doctor and ask for clarification.
Dr. Fox is committed to ensuring your comfort and understanding.

Podiatric Pain Analysis Survey
H. Craig Fox, DPM
Fox River Foot and Ankle Centers, P.C.

Fox Foot and Ankle Podiatry .com
H. Craig Fox, DPM

Patient Name_____
Primary complaint/reason for coming to practice today:_____
_____
Does the condition disrupt your lifestyle and activities of daily living? ❑Yes ❑No
Did the condition result from an accident or injury? ❑Yes ❑No If yes, please detail:_____
_____
_____
Name of Primary Physician: _____
Date Last Seen by Primary Physician:_____

Is this condition causing or are you suffering with any of the following:

I Have Tingling/Numbness/Pain To:

	Right	Left	Both
❑Legs	❑	❑	❑
❑Ankle	❑	❑	❑
❑Feet	❑	❑	❑
❑Toes	❑	❑	❑

I Have Difficulty with:

❑Standing ❑Bending
❑Walking ❑Lifting
❑Sitting ❑Kneeling

Nature of pain: ❑Sharp ❑Dull ❑Throbbing ❑Constant ❑Intermittent
How long have you been suffering with this condition? ❑Days ❑Weeks ❑Months ❑Longer

Please check any prior treatments received (at this office or any other):

❑Injections ❑Orthotics ❑Over the counter inserts
❑Non-steroidal anti-inflammatory medication ❑Braces/immobilizers
❑Physical therapy ❑Ice ❑Rest ❑None

Please check any additional conditions you are currently experiencing or suffering from:

	Right	Left	Both
❑Flat feet	❑	❑	❑
❑Heel or arch pain	❑	❑	❑
❑Leg pain (shin splints)	❑	❑	❑
❑Achilles tendon pain	❑	❑	❑
❑"Toe in" or "Toe out" gait (walking)	❑	❑	❑
❑Ankle swelling/stiffness	❑	❑	❑
❑Back pain	❑	❑	❑
❑Legs feel heavy, tired, restless or achy	❑	❑	❑
❑Pain with first step in the morning	❑	❑	❑

	Right	Left	Both
❑Pain in feet or legs with activity	❑	❑	❑
❑Feet/toes feel numb	❑	❑	❑
❑Foot/toes/legs burn	❑	❑	❑
❑Discoloration of toes/foot	❑	❑	❑
❑Warts	❑	❑	❑
❑Non/poor healing sore on leg or foot	❑	❑	❑
❑Ankle instability (easy twisting injuries)	❑	❑	❑
❑Pain in ball of foot	❑	❑	❑
❑Deep Vein Thrombosis with pain/swelling	❑	❑	❑

❑Nail problems ❑Yellowed ❑Thick ❑Painful ❑Discolored ❑Ingrown
❑Coumadin (blood thinner) use

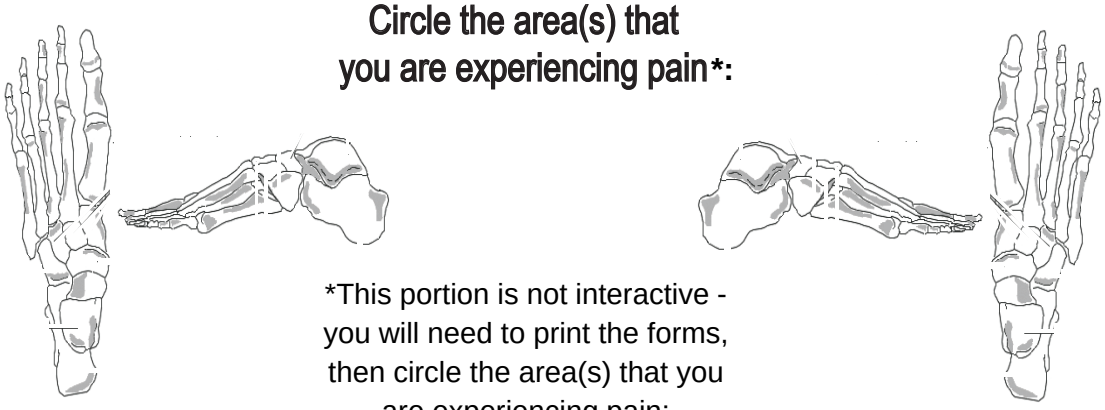
_____ _____
Patient /Guardian Signature **Date**

Family Medical History – Check all that apply

MEDICAL PROBLEM	SELF	FAMILY	Father (F) Mother (M) Child(C) Sibling(S) Grandparent(G)	Unknown To Patient
Cancer (type)_____	❑	❑	F❑ M❑ C❑ S❑ G❑	❑
Diabetes	❑	❑	F❑ M❑ C❑ S❑ G❑	❑
High Blood Pressure	❑	❑	F❑ M❑ C❑ S❑ G❑	❑
Heart Disease/Stroke	❑	❑	F❑ M❑ C❑ S❑ G❑	❑
High Cholesterol	❑	❑	F❑ M❑ C❑ S❑ G❑	❑
Liver/Gall Bladder Disease	❑	❑	F❑ M❑ C❑ S❑ G❑	❑
Epilepsy	❑	❑	F❑ M❑ C❑ S❑ G❑	❑
Multiple Births	❑	❑	F❑ M❑ C❑ S❑ G❑	❑
Birth Defects	❑	❑	F❑ M❑ C❑ S❑ G❑	❑
Thyroid Problems	❑	❑	F❑ M❑ C❑ S❑ G❑	❑
Depression	❑	❑	F❑ M❑ C❑ S❑ G❑	❑
Bladder/Kidney Infections	❑	❑	F❑ M❑ C❑ S❑ G❑	❑

Pain scale 1-10, 10 is worst. Please check the number that applies:
1❑ 2❑ 3❑ 4❑ 5❑ 6❑ 7❑ 8❑ 9❑ 10❑

Circle the area(s) that you are experiencing pain*:



*This portion is not interactive - you will need to print the forms, then circle the area(s) that you are experiencing pain:

Left Foot

Right Foot

Nature of pain:

❑Sharp ❑Dull ❑Throbbing ❑Constant ❑Intermittent

Billing Policy For Fox River Foot and Ankle Centers, P. C.

Thank you for choosing H. Craig Fox, DPM and Fox River Foot and Ankle Centers P.C. as your podiatric care provider. It is our goal to make your treatment comfortable from both a service and financial standpoint. Therefore, if you have any questions or concerns, please do not hesitate to ask our billing staff.
All co-pays (the amount you pay each time you see a doctor...the co-pay amount is determined by your specific insurance plan, and is often listed on your insurance card) are due in full at the time of service. We accept cash, check, Visa, Mastercard, and Discover Card.

When agreeing to be treated at our practice, you agree to the following statement:
"I agree that if my account becomes delinquent, I will pay a collection fee of 25% of the total owed when sent to collection incurred by Fox River Foot and Ankle Centers, P.C, including, but not limited to, court costs and reasonable attorney's fees. I understand my account may be forwarded to a collection agency if an unpaid balance remains after 120 days, unless I make other arrangements with Fox River Foot and Ankle Centers, P.C. I also understand that there is a 1.5% monthly late charge assessed on all balances after 120 days past due. There will be a $30.00 service charge added for each check tendered in payment that is not honored for any reason. I authorize Dr. H. Craig Fox and the staff at Fox River Foot and Ankle Centers, P.C. to treat me for my foot and ankle (podiatric) problems. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician.
I understand that I am financially responsible for any balance remaining after insurance has paid. I also authorize Fox River Foot and Ankle Centers, P.C. or my insurance company to release any information required to process my claims. I acknowledge that I have received Notice of Privacy Practices which are compliant with HIPPA. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. **I have read and fully understand this agreement. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.**

_____ _____

Patient/Guardian Signature **Date**

_____

Relationship of Parent/Guardian to patient

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FOX FOOT AND ANKLE.COM
PODIATRY

H. CRAIG FOX, DPM

Release of Private Health Information

To: H. Craig Fox, DPM and Fox River Foot and Ankle Centers, P.C.

To ensure proper and timely handling of your medical information, please provide us with the following information:

I authorize the above named physicain and Fox River Foot and Ankle centers, P.C. to release any and all medical test results or other private health information. Please initial your choices that are acceptable to you. If you do not want an option, leave it **blank** to indicate we **do not** have permission to use that choice.

_____May leave message at work to call the office.
_____May leave a message on answering machine/voice mail to call the office.
_____May leave a message with a family member to call the office.
_____May leave a test result on an answering machine/voice mail.
_____May give test results to a designated person:
Name:_____
Relationship:_____
_____May release test results only to myself.

I understand this Release will be in effect unless changed or revoked by myself either in writing or by completing a new release.

_____ _____
Patient Name (please print) **Date**

_____ _____
Address **Date of Birth**

_____
Patient/Guardian Signature

_____
Witness

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding
the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **09/23/ 13**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party ñbusiness associatesò that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Sale of Health Information: We will not sell or exchange your health information for any type of financial remuneration without your written authorization.

Fundraising Communications: We may use or disclose your health information for fundraising purposes, but you have the right to opt-out from receiving these communications.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that personôs involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. If we are paid by a third party to make marketing communications to you about their products or services, we will not make such communications to you without your written authorization. Except as stated above, no other marketing communications will be sent to you without your authorization.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make

repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workersô compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you **25¢** for each page, **$15.00** per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If the Practice keeps your health information in electronic form, you may request that we send it to you or another party in electronic form. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your non-electronic protected health information for purposes other than treatment, payment, health care operations and certain other activities during the past six (6) years. For disclosures of electronic health information, our duty to provide an accounting only covers disclosures after January 1, 2011 [January 1, 2014] and only applies to disclosures for the three (3) years preceding your request. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. Except as noted herein, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). We are required to accept and follow requests for restrictions of health information to insurance companies if you have paid out-of-pocket and in full for the item or service we provide to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your

request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Notice of Unauthorized Disclosures: If the Practice causes or allows your health information to be disclosed to an unauthorized person, the Practice will notify you of this and help you mitigate the effects.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name of Contact Person: **Cheryl Fox, Fox River Foot & Ankle Centers, P.C.**

Telephone: **630-551-3338** Fax: **630-551-4117**

Address: **3963 Route 34 Oswego IL 60543**

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature