WISCONSIN FOOT CENTER, LLC
step forward
11035 W Forest Home Avenue Suite 120
Hales Corners, WI 53130
414-425-8400

PATIENT INFORMATION FORM

PLEASE PRINT

DATE: _____ **PATIENT'S NAME:** _____

NICKNAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____ □**MALE** □**FEMALE**

PARENT OR GUARDIAN (IF A MINOR): _____

ADDRESS: _____ **APT:** _____ **CITY**_____

STATE: _____ **ZIP:** _____ **EMAIL:** _____

HOME PHONE: _____ **WORK PHONE:** _____ **CELL PHONE:** _____

S.S. #: _____ **EMPLOYER:** _____

PRIMARY LANGUAGE: _____ **RACE:** _____ **ETHNICITY:**_____

EMERGENCY CONTACT: _____ **PHONE:** _____

RELATIONSHIP:_____

MEDICAL HISTORY

REASON FOR SEEING DOCTOR TODAY:_____

PREVIOUS FOOT, ANKLE, OR LEG PROBLEM: _____

DO YOU WEAR ORTHOTICS IN YOUR SHOES? _____

LIST ANY OTHER OPERATIONS & DATES: _____

HEIGHT: ____**FT** _____**INCHES** **WEIGHT:** _____**LBS** **SHOE SIZE:** _____

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

□ **HEART TROUBLE**	□ **DIABETES**	□ **HARDENING OF THE ARTERIES**
□ **KIDNEY TROUBLE**	□ **BONE FRACTURES**	□ **RAYNAUD'S DISEASE**
□ **HIGH BLOOD PRESSURE**	□ **ASTHMA**	□ **VARICOSE VEINS**
□ **POLIO**	□ **ANEMIA**	□ **ARTHRITIS**
□ **RHEUMATIC FEVER**	□ **BLOOD DISEASE**	□ **CANCER**
□ **TUBERCULOSIS**	□ **CIRCULATION DISEASE**	□ **SEIZURE DISORDER/EPILEPSY**
□ **STOMACH ULCERS**	□ **LIVER TROUBLE**	□ **HIV**
□ **PROLONGED BLEEDING**	□ **STROKE/TIA**	□ **HEPATITIS A B C**

OTHER: _____

FAMILY PHYSICIAN/PHONE: _____

PHARMACY/PHONE: _____

REFERRED BY: _____

FORMER PODIATRIST: _____

CURRENT MEDICATIONS: _____

ALLERGIES: □ **NONE**

□**PENICILLIN** □**CODEINE** □**CORTISONE** □**ANESTHETICS** □**ASPIRIN** □**VICODIN** □**IODINE**

□ **OTHER:** _____

DO YOU SMOKE? □ **NEVER** □ **NO** □**YES** _____**PACKS/DAY** **HOW MANY YEARS?** _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

INSURED: _____ **INSURED DATE OF BIRTH:** _____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

SECONDARY INSURANCE COMPANY: _____

INSURED: _____ **INSURED DATE OF BIRTH** _____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

Permission to treat: I hereby authorize Dr. Andrew J. Marso to perform such general procedures as he may deam 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.

SIGNATURE (PATIENT OR GUARDIAN): _____**DATE:** _____

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.

SIGNATURE (PATIENT OR GUARDIAN): _____**DATE:** _____

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours' notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours' notice, we are unable to offer that slot to other patients. Office appointments which are cancelled with less than 24 hours notification may 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 appointment will be considered as NO SHOW. Patients who No-Show three (3) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to Kathy or Rachel (414-425-8400). Please sign that you have read, understand and agree to this Cancellation and No show Policy.

_____ Patient Name (Please Print)

_____ Signature of Patient

_____Date

WISCONSIN FOOT CENTER PAYMENT POLICY

Thank you for choosing Wisconsin Foot Center as your podiatric provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read and sign below in the space provided. A copy will be provided to you upon request.

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 an up to date 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 payment 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. 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. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ Date: _____