FOOT MECHANICS OF LAKE COUNTY

Specializing in all Foot & Ankle Disorders
4129 Old Grand Ave
Gurnee, IL 60031
Rick Ginsberg, DPM
Phone: 847-457-4562
Fax: 847-239-6740
Email: Scheduling@myfootmechanic.com

Date:_____

Patient Name_____ Social Sec#_____ Birthdate_____ Age _____
Last First MI

Address _____ Sex ☐ M ☐ F Marital Status_____
Street City State Zip

Race _____ Ethnicity _____Preferred Language _____ How were you referred? _____

Phone # (Home) _____ (Cell) _____ Email _____

Emergency Contact _____ Relationship _____ Phone# _____

Primary Insurance _____ Group/ID# _____ Subscriber's Name _____

Secondary Insurance_____ Group/ID# _____ Subscriber's Name _____

MEDICAL HISTORY

Chief Foot Complaint_____ Any personal or family history of diabetes ☐ Yes ☐ No

Have you been seen by a podiatrist before ☐ Yes ☐ No Date of last visit _____

Occupation_____ Athletic activities which you participate _____

Have you ever smoked ☐ Yes, ☐ No Packs/Day _____ Years _____

Do you smoke now ☐ Yes, ☐ No Packs/Day_____ Years _____

Alcoholic Beverages? None Rarely Moderately Daily Quit

Please check any of the foot problems listed below that you now have or have had in the past.

__Ankle Pain ___Athlete's Foot ___Bunions ___Corns/Calluses ___Flat Feet ___Foot/Leg Cramps
__Heel Pain ___Ingrown Toenails ___Numbness ___Plantar Warts ___Swelling ___Tired Feet

Please check any of the conditions listed below that you have or have had in the past.

__Tuberculosis	___*Knee or Hip Replacement*	___Dementia	___Back Problems	___*Anticoagulant Therapy*	
__Anemia	___*Artificial Heart Valve*	___Epilepsy	___Liver Disease	___Rheumatic Fever	___Shortness of Breath
__*Neuropathy*	___*Peripheral Vascular Disease*	___Meningitis	___Hepatitis or Jaundice	___Rash	___COPD
__Fall Risk	___High Blood Pressure	___Fainting	___Phlebitis	___Kidney Disease	___Asthma
__Heart Disease	___Low Blood Pressure	___Gout	___Psychiatric Care	___High Cholesterol	___Cancer
__Edema	___Circulatory Problems	___Weight Loss	___*Diabetes NIDDM*	___Osteoporosis	___Radiation Treatment
__Chest Pain	___Stroke	___Headaches	___*Diabetes IDDM*	___Hypothyroidism	___HIV
__Arrhythmia/Afib	___Varicose Veins	___Ulcers	___Hemophilia	___Respiratory Disease	___*Vascular Bypass*

MEDICAL HISTORY

Please list prior **surgeries** and **hospitalizations** with dates.

Family Physician _____ Last Visit _____
Name Phone

Please check off any allergies you have.

___Adhesive Tape ___Anticoagulant Therapy __Aspirin ___Codeine ___Demerol ___Iodine
___Local Anesthetics ___Novocain __Penicillin ___Seafood ___Sulfa

Other _____

MEDICATIONS

Please **list all prescriptions**, over-the-counter **medication** and **vitamins**.

MEDICATION	DOSE	FREQUENCY

Pharmacy _____
Name Phone #

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary. I authorize the release of medical or other information necessary to process this claim. I authorize payment of medical benefits to the physician for all services.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

FOOT MECHANICS OF LAKE COUNTY
FINANCIAL POLICY

Thank you for choosing Dr Rick Ginsberg as your podiatric physician. We are committed to providing the best podiatry care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our financial policy in which we ask that you read, sign and return to us prior to your treatment.

Regarding Insurance
We participate in all major medical insurance plans. It is the responsibility of the patient/guardian to provide accurate and complete personal and insurance information. We accept assignment of benefits from most insurance companies but in some cases the person who is financially responsible will be held liable for all balances not covered by insurance. It is ***your responsibility*** to understand and comply with any predetermination of benefits. For HMO's, EPO's and POS's policies, it is the patients' responsibility to obtain a referral and all necessary requirements needed for insurance purposes. **Please be aware that some and perhaps all of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by any other medical insurance companies.**

Usual and Customary Rates
We are committed to providing the best treatment for our patients and we charge what we believe to be reasonable and customary fees for our region of specialty. Based on the contracted fee schedule between our practice and your insurance company you will be responsible for what insurance notifies us as your responsibility. As a courtesy, we verify insurance benefits for certain medical procedures and devices. However, **benefits quoted to us, is not a guarantee of coverage until your claim is submitted and processed by your insurance company.**

Past Due Accounts
Accounts with outstanding balances will be, considered past due after **30days. 5%** interest will be charged for all balances **30 days** or **older**. If the balance has not been resolved or payment arrangements have not been made for **90 days** your account will be considered delinquent and referred to a collection agency. **All legal fees and collection fees to secure past due balances will be added to your account.**

Co-Pays
Co-pays are due at the time services are rendered.

Copy of Health Records
We will copy your health records for $2.00 per page. Copies of X-rays are $15.00 per foot pre series. All outstanding balances are due prior to the release of records. Please allow two weeks for copies to be processed before picking them up. Once copies of medical records/
X-rays have been made, per the patient's request, and you do not pick them up; the charge for the copies **will still** be your responsibility. Payment for copies will be required before mailed or at the time of pick up.

Missed Appointments and Late Cancellations
If you are unable to keep an appointment with our office, **24hr notice** must be given to avoid a no-show fee. Failure to give **24 hrs** notice ***will result in a $50.00 NO SHOW fee***. **This fee is due upon receipt at your next scheduled appointment otherwise we reserve the right to reschedule your appointment until payment is made**. **Appointment reminder phone calls are made when possible as a courtesy and **will not be used** as an excuse for missed appointments.*
If you are more than 15 minutes late for your appointment, we cannot guarantee you can be seen by the doctor on that day; your appointment may have to be rescheduled depending on time availability.

Methods of Payment
For your convenience, we accept cash, checks, Visa and Master Card. There is a **$10.00** Minimum for credit transactions.

Returned Checks
Your check is welcome in our office. Checks returned to us as unpaid by your bank you will be held liable for the amount in which the check was written as well as the NSF fee of $45.00. After (3) three returned checks we will no longer accept your personal check.

*No mobile information will be shared with third parties/affiliates for marketing/promotional purposes. All the above categories exclude text messaging originator opt-in data and consent; this information will not be shared with any third parties

If you should have any questions or concerns, please feel free to contact our Billing Department at (866) 505-6724 x-420.

By signing below I have read, understood and agree to the Privacy Practices and Financial Policy of Foot Mechanics of Lake County, P.C.

_____	_____	_____
PRINT PATIENT NAME	***SIGNATURE OF PATIENT/GUARDIAN***	***DATE***

Foot Mechanics of Lake County
4129 Old Grand Ave, Gurnee, IL 60031
Phone: 847-457-4562 Fax: 847-239-6740
www.myfootmechanic.com

STATEMENT OF CERTIFYING PHYSICIAN FOR ROUTINE FOOT CARE COVERAGE

Patient Name: **Date of Birth: _____**

While the Medicare program generally excludes routine foot care services from coverage, there are specific indication or exceptions under which there are program benefits.

Medicare payment may be made for routine foot care when the patient has a systematic condition that services by a nonprofessional person would put the patient at risk (for example, a systemic condition that has resulted in severe circulatory embarrassment or areas of desensitization in the patient's leg or feet). In addition, routine foot care procedure is reimbursable only if the patient is under the active care of a Doctor of Medicine or Osteopathy (MD or DO) or qualified non-physician practitioner for the treatment and/or evaluation of the complicating disease process during the six (6) months period prior to the rendition of the routine-type service.
Please review the attached list of clinical findings and indicate which systemic illness qualifies the patient for covered routine foot care.

I certify that the following statements are true (please check all that apply):

This patient has one or more of the following conditions:
Please mark all that apply, and at least one must be marked:

____ Peripheral Vascular Disease I73.89
____ Neuropathy/polyneuropathy G62.89
____ Multiple Sclerosis G35
____ Rheumatoid Arthritis with rheum. factor w/o organ or systems involvement M05.771/2
____ Diabetes with neurologic complications; Please list diabetes code: _____
____ Diabetes with circulatory complications; Please list diabetes code: _____
____ Other Diabetes diagnosis with complication; Please list diabetes code: _____
____ Other applicable systemic disease code(s): _____, _____, _____
*Code will need verification for coverage on Medicare approved list
____ None/Patient does not qualify.

I certify that I am treating this patient under a comprehensive care plan, and I have re-evaluated this patient within the previous six (6) months period.

Date last seen: _____

Physician Signature: _____ Date: _____

Physician Name (Printed):

_____

FOOT MECHANICS OF LAKE COUNTY, P.C.
Specializing in all Foot and Ankle Disorders

CK GINSBERG, DPM
29 Old Grand Ave
ırnee, IL 60031
7-457-4562

Email: footmechanic@gmail.com
Fax: (847) 239-6740

HIPAA DISCLOSURE OF MEDICAL INFORMATION

I _____ authorize the methods of communication of my protected health information by Foot Mechanics of Lake County, P.C. as indicated below. I understand that under the HIPAA guidelines, my patient information is held confidential unless authorized by my signature, except for payment operations.

The following person(s) can inquire Protected Health Information, pick up records, prescriptions, take messages regarding my lab results, physician messages and appointment reminders with my Doctor and/or their staff at Foot Mechanics of Lake County, P.C..

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____

Please initial each option you authorize:

Telephone Answering Machine: ____Home ____Work ____Cell Phone Via E-Mail: ____

Mail to Home: ____ Patient's Cell Phone #: _____

Patient's E-Mail: _____

Signature of Patient: _____ Date: _____

Printed Patient's Name: _____ Date: _____

SMS Disclosure and Privacy Policy: By checking Cell phone: **1).** Message and Data rates may apply. Message frequency will vary **2).** Reply STOP to opt out of messaging. **3).** Reply HELP for customer care contact information. **4).** I have read and acknowledge the Privacy Policy. No mobile information will be shared with third parties/affiliates for marketing/promotional purposes. All the above categories exclude text messaging originator opt-in data and consent; this information will not be shared with any third parties

Legal Guardian (If Applicable)

Signature: _____ Date: _____

Printed Guardian Name: _____ Date: _____

This release may be rescinded at any time in writing from the patient/legal guardian. Please note: Foot Mechanics Of Lake County HIPAA policy is in effect for the entire time you are a patient of ours not just for the date that you sign the policy. If you have any changes we will have you fill out a new form at that time.

NOTICE OF PRIVACY POLICIES

FOR

FOOT MECHANICS OF LAKE COUNTY, P.C.

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE READ CAREFULLY

INTRODUCTION

Foot Mechanics of Lake County is committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how we use or disclose the personal information. It also describes your rights as they relate to your protected health information. This notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Foot Mechanics of Lake County, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal documentation describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

- Although your health record is the physical property of Foot Mechanics of Lake County, the information belongs to you. You have a right to:
- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accou8nting of disclosures of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Foot Mechanics of Lake County is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as our legal duties and privacy practices with respect to information we collect about you,
- Abide by all terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative locations.

We reserve the right to change our practices and make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notices to the address you've supplied us, or if you agree, we will mail the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact Foot Mechanics of Lake County at 847-239-4756.

If you believe your privacy has been violated, you can file a complaint with Foot Mechanics of Lake County, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either Dr Rick Ginsberg or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S Department of Health and Human Services
200 Independence Avenue, S.W
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse. Physician, or other member of your health care team will be recorded in your record and used

to determine the course of treatment that work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will them record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or subsequent health care provider with copies of various reports that should assist him or her in treating you once you're this hospital.

We will use your health information for payment

For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedure, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates Examples include physician services in the emergency department, and radiology, certain lab tests, and a copy service we use when making copies of you health record. When these services are contracted, we may disclose your health information to our business associates that they can perform the job we've asked them to do and bill you our your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend. Or any other person you identify, health information relevant to that person's involvement in you care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board, which has reviewed the research proposal, and established protocols to ensure the privacy of your health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders of information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have violated professional of clinical standards and are potentially endangering one or more patients, workers or the public.

No mobile information will be shared with third parties/affiliates for marketing/ promotional purposes. All the above categories exclude text messaging originator opt-in data and consent; this information will not be shared with and third parties.