Gelbmann Podiatry

☐ 1440 S Michigan Ave, Chicago, IL 60605

☐ 1700 W Chicago Ave, Chicago, IL 60622

Tel: 312-880-0067 | Fax: 312-880-0071

Please fill out completely or mark areas "n/a" if they do not apply

PATIENT INFORMATION:

Name _____ Birth Date _____ Sex:

Social Security Number _____ Marital Status

Race: Ethnicity:

Address:

City/State **Zip**

PRIMARY Phone (____) ____-____ Email:

Are you employed? Name of Employer:

Emergency Contact _____ Relationship _____

Home Phone (____) ____-_____ Cell Phone (____) ____-_____ Other (____) ____-_____

PRIMARY CARE DOCTOR:

_____ Phone: (____) ____-_____ _____

NAME OF PCP **DATE LAST SEEN**

INSURANCE: *Please give **ALL** cards to the receptionist so we may copy them to your patient chart.*

Primary Insurance Company Name _____

Secondary Insurance Company Name _____

RESPONSIBLE PARTY: *The person who supplies the patient's insurance or who is responsible for payment if uninsured*

Name _____ Social Security Number _____ DOB _____

Relation to Patient _____ Phone (____) ____-_____ Other (____) ____-_____

PHARMACY INFORMATION:

_____ _____ Phone (____) ____-_____

NAME OF PHARMACY **CITY/ZIP CODE**

I certify that the above insurance information is current and accurate; I authorize assignment of insurance to Gelbmann Podiatry. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Gelbmann Podiatry and its representatives may use my health care information and may disclose such information to the above-named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services received. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____ _____

PATIENT NAME (PRINT) **PATIENT SIGNATURE** **DATE**

All information provided on this form will remain confidential in compliance with our HIPAA guidelines

Medical History

Have you ever been treated for (select all that applies):

- ☐ Corns/Calluses
- ☐ Fungal Nails
- ☐ Leg/Foot Ulcers
- ☐ Broken Foot/Bone
- ☐ Hammer/Mallet Toe
- ☐ Arch pain
- ☐ Lower Back Pain
- ☐ In-Toeing
- ☐ Warts
- ☐ Ingrown Nails
- ☐ Foot Numbness
- ☐ Broken Ankle
- ☐ Leg/Foot Cramp
- ☐ High Arch Feet
- ☐ Heel Pain
- ☐ Toe Walking
- ☐ Athlete's Foot
- ☐ Neuroma
- ☐ Bunions
- ☐ Ankle Sprain
- ☐ Flat Feet
- ☐ Knee Pain
- ☐ Rash
- ☐ Gait Problems
- ☐ Childhood Foot Problems

Do you get leg cramps after activity?

Does foot pain limit your desired activities?

Do you have any difficult walking?

Any pain in the calves or buttocks when walking?

Is the pain relieved by stopping & standing still?

List the sports and other actives in which you are involved:

_____

_____

_____

Patient Medical History: Have you ever been treated for:

- ☐ Stroke
- ☐ Phlebitis
- ☐ Anemia
- ☐ Diabetes
- ☐ Gout
- ☐ Sciatica
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Asthma
- ☐ Hepatitis
- ☐ Dark Urine
- ☐ Cancer
- ☐ Heart Attack
- ☐ Vascular Disease
- ☐ Poor Circulation
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Lyme's Disease
- ☐ Headaches
- ☐ Nerve Disorder
- ☐ Lung Disease
- ☐ Liver Disease
- ☐ Chronic Light Stool
- ☐ Stomach Ulcer
- ☐ High Blood Pressure
- ☐ Heart Condition
- ☐ Eyes: Glaucoma
- ☐ Keloid/Thick Scar
- ☐ Alzheimer's
- ☐ Rheumatic Fever
- ☐ Hearing/Ear Disorder
- ☐ Psychiatric Disorder
- ☐ Tuberculosis
- ☐ Thyroid Problem
- ☐ Weight Loss
- ☐ None of the above

Other: _____

Surgical History: Surgical procedures and complications:

_____

_____

_____

Past Family & Social History

List immediate family members who have had:

Diabetes _____ Foot Problems _____

Arthritis _____ Heart Attack _____

Stroke _____ High Blood Pressure _____

Cancer _____ Birth Defects _____

# of Childbirths ____ Are you currently pregnant?

Are you slow to heal after cuts

Any abnormal bruising, bleeding or scarring?

Do you smoke now?

Did you ever smoke?

If you quit, what year did you do so? _____

Alcohol use? ☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit

Recreational Drugs?

Are you currently taking any medications?

Are you taking Insulin?

List medications, dose & purpose below:

_____

_____

_____

_____

_____

_____

Are you taking your medications as prescribed?

Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

Latex, Adhesive tape	☐	Penicillin	☐
Other antibiotics	☐	Empirin, Tylenol	☐
Aspirin, Advil, Aleve, Motrin	☐	Celebrex	☐
Other pain remedies	☐	Morphine	☐
Codeine	☐	Other narcotics	☐
Novocaine	☐	Other anesthetics	☐
Sulfa drugs	☐	Shrimp, Iodine or Merthiolate	☐

Clearly list additional medication, drugs, foods, etc.

_____

_____

_____

_____

Review of Systems: Are you currently experiencing any of the following:

General:	☐ Decreased Strength	☐ Weight change	☐ Decreased exercise tolerance	
Head:	☐ Headaches	☐ Vertigo	☐ Injury	
Eyes:	☐ Abnormal vision	☐ Double vision	☐ Diminished vision	☐ Increased drainage ☐ Pain
Ears:	☐ Change in hearing	☐ Tinnitus	☐ Bleeding	☐ Vertigo
Nose:	☐ Nose bleed	☐ Obstruction	☐ Discharge	☐ Inflammation of mucous membrane
Mouth:	☐ Dental difficulties	☐ Gum bleeding	☐ Use of dentures	
Neck:	☐ Stiffness	☐ Pain	☐ Tenderness	☐ Noted masses
Chest:	☐ Shortness of breath	☐ Wheezing	☐ Cough	☐ Spitting up blood
Heart:	☐ Chest pains	☐ Palpitations	☐ Fainting	☐ Breathlessness
Abdomen:	☐ Difficulty Swallowing	☐ Appetite change	☐ Vomiting	☐ Bowel habit changes ☐ Tarry Stool ☐ Pain
Neurologic:	☐ Weakness	☐ Tremor	☐ Seizures	☐ Changes in mentation ☐ Lack of muscle control
Psychiatric:	☐ Depressive symptoms	☐ Change in sleep habits		☐ Changes in thought content

GELBMANN PODIATRY

HIPPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began in December 2022. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete test is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

We have adopted the following policies:

I. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

II. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

III. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

IV. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

V. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

VI. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

VII. We agree to provide patients with access to their records in accordance with state and federal laws.

VIII. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

IX. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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Fees and Payments

I understand that it is my responsibility to confirm that the provider that I see at Gelbmann Podiatry is a participating provider under my policy.

Further, I understand that my insurance company may not cover 100% of my bills for services provided, and that I will be responsible for the payment of any remaining balance.

I understand that it is my responsibility to provide Gelbmann Podiatry with appropriate and current insurance information, and to notify Gelbmann Podiatry immediately of any changes to my insurance coverage to ensure efficient claims, billing, and payment.

In the event that I fail to provide all necessary and current insurance information, I understand that my insurance company(ies) may deny payment for claims relating to services rendered to me, and I understand that I may be fully responsible for my entire account balance.

Furthermore, I understand that it is my responsibility to have obtained any and all necessary referrals and authorizations required prior to treatment by Gelbmann Podiatry. If my insurance plan requires a referral and I do not have one, I understand that I will be responsible for the entire bill for rendered services, or I will provide the referral to the office before I leave.

I understand that I will be responsible for co-payments, deductible payments, and any other fee relating to services that are not fully or partially covered by my insurance company(ies). I understand that if my insurance requires a copay or coinsurance payment, the payment is due at the time of service.

_____

Print Name

_____

Signature

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.

_____

Print Name

_____

Signature

GELBMANN PODIATRY

1440 S. Michigan Ave, Chicago IL 60605
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1700 W. Chicago Ave, Chicago IL 60622
P: 312-243-3330 F: 312-880-0071

Cancellation and No Show Policy

All patients will be charged a fee of ***$50 each time*** they cancel, reschedule, or do not show up for a scheduled appointment on the same day as the appointment.

I understand that this fee will need to be paid in full before I am to be seen again by the doctor.

I hereby understand and agree to this policy. Furthermore I promise to make every attempt to inform Gelbmann Podiatry as soon as possible should I need to cancel or reschedule an appointment.

Name: _____

Signature: _____

Date: _____