

Brian Dunn, D.P.M. • Mark Sack, D.P.M.
108 Bartlett Ave, Bartlett, IL 60103
PH: (630) 483-2212 – Fax: (630) 483-2237

BARTLETT FOOT CENTER PRIVACY PROMISE FOR PATIENTS

While information is the cornerstone of our ability to provide superior medical service, our most important asset is our patient's trust. Keeping patient information secure, and using it only as our patients would want us to, is a top priority for all of us at the Bartlett Foot Center. Here, then, is our promise to our individual patients:

1. We will safeguard, according to strict standards of security and confidentiality, any information our patients share with us.
2. We will limit the collection and use of patient information to the minimum we require to deliver superior medical service to our patients.
3. We will permit only authorized employees, who are trained in the proper handling of patient information to have access to that information. Employees who violate our Privacy Promise will be subject to our normal disciplinary process.
4. We will not reveal patient information to any external organization unless we have previously informed the patient in disclosures or agreements, have been authorized by the patient or are required by law.
5. Whenever we hire other organizations to provide support service, we will require them to conform to our privacy standards and to allow us to audit them for compliance.
6. For purposes of credit reporting, verification and risk management, we will exchange information about our patients with reputable reference sources and clearinghouse services.
7. We will not use or share – internally or externally – personally identifiable medical information for any purpose other than the underwriting or administration of a patient's policy, claim or account, as disclosed to the patient when the information is collected, or to which the patient consents.
8. We will attempt to keep patient files complete, up to date, and accurate. We will tell our patients how and where to conveniently access their information (except when we're prohibited by law) and how to notify us about errors, which we will promptly correct.

We will continuously assess ourselves to ensure that patient privacy is respected. We will conduct our business in a manner that fulfills our promise in the many locations in which we do business. Additionally, we are committed to protecting information we may have about our patients. If you wish to verify that the information we have about you is correct, simply write us or tell us. To examine certain information we have in our files about you, send your name, policy or account number and social security number to us at:

Privacy Officer
108 Bartlett Ave.
Bartlett, IL 60103

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HIPPA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third party payers.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed of your Privacy Promise for Patients containing a more complete description of the uses and disclosure of my health information.

I have reviewed your Privacy Promise for Patients prior to signing this consent.

I understand that this organization has the right to change its notice of Privacy Promise for Patients from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Privacy Promise for Patients.

If I have any other questions or concerns regarding my privacy, I understand that I can speak with my physician in person or in writing.

Patient's Name

Date

Signed (Patient or Legal Representative for Patient)

Relationship to Patient

Bartlett Foot Center

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Consent to Treat a Minor
Caregiver other than Parent/Legal Guardian

Patient Name

Date of Birth

LAST FIRST MONTH DAY YEAR

I, _____
FULL NAME OF PARENT(S) OR LEGAL GUARDIAN

above guardian of the above named child give the following adults to make decisions regarding the treatment of my child. I understand that only myself and those listed below will have authority to authorize treatment.

NAME (AUTHORIZED CAREGIVER) PHONE RELATIONSHIP TO PATIENT

NAME (AUTHORIZED CAREGIVER) PHONE RELATIONSHIP TO PATIENT

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I understand that any person bringing the patient in for treatment not listed above must have a letter of consent from me or treatment could be refused or delayed. I understand that in an emergency, efforts will be made to contact me prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached.

I have read all the information on this sheet and certify that the information I have provided here is true and correct.

Signature Relationship to Minor Date

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED

USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF ALCOHOL ABUSE
 CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE DAILY

USE OF TOBACCO: NEVER QUIT - HOW LONG AGO? _____ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: NEVER QUIT - HOW LONG AGO? _____ TYPE _____
 CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? 10% 25% 50% 75% 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? CHILDREN-AGE(S) _____ PET(S)-WHAT KIND? _____
 ELDERLY OR DISABLED FAMILY MEMBER OTHER _____

EXERCISE: NEVER RARE OCCASIONAL WEEKLY SEVERAL TIMES A WEEK DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: DIABETES: TYPE 1 OR TYPE 2 CANCER HEART DISEASE
 HIGH BLOOD PRESSURE STROKE CORONARY ARTERY DISEASE THYROID DISEASE
 RHEUMATOID ARTHRITIS
 OTHER _____

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____

YOUR MEDICAL HISTORY

ALLERGIES: MEDICATIONS _____
 ANESTHESIA _____ FOODS _____
 TAPE LATEX SHELLFISH IODINE OTHER _____
 NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

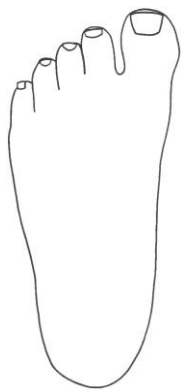
ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

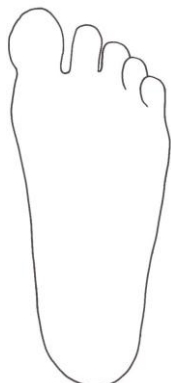
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT



BOTTOM OF FOOT

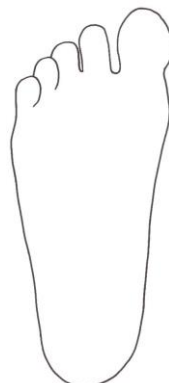


INSIDE OF FOOT

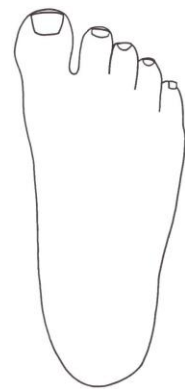


OUTSIDE OF FOOT

RIGHT FOOT



BOTTOM OF FOOT



TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: BEGIN ALL OF A SUDDEN GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? NO PAIN SHARP DULL ACHING BURNING
 RADIATING ITCHING STABBING OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: STAYED THE SAME BECOME WORSE IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? WALKING STANDING DAILY ACTIVITIES
 RESTING DRESS SHOES HIGH HEELS FLAT SHOES ANY CLOSED TOE SHOE
 RUNNING OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? YES (DESCRIBE) _____ No
IF YES, WAS IT A WORK-RELATED INJURY? YES NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS. I GIVE MY PERMISSION TO THE DOCTOR TO ADMINISTER AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY FOR DIAGNOSIS AND / OR TREATMENT.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

SIGNATURE OF DOCTOR

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

DATE

SIGNATURE

DATE

**Bartlett Foot Center
Dr. Brian Dunn • Dr. Mark Sack**

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of \$25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____

_____ Patient/Responsible Party initials to indicate copy received.