Family Foot and Ankle Clinic Paul Sommer, DPM, FACLES
(219) 477 – Foot (3668)
www.familyfoot.com
Facebook: Paul Sommer Podiatry
Valparaiso ~ Chandana Pointe ~ 1610 Pointe Drive
DeMotte ~ DeMotte Clinic ~ 520 S. Halleck

Welcome to Family Foot & Ankle Clinic.

Excellent patient care is our goal. We want you to be well informed and satisfied with your medical care at Family Foot & Ankle Clinic.

Please take a few moments to fill out the enclosed papers. **All pages and lines should be completed.** Filling them out in their entirety will help us with your registration information and medical information. You will need to bring all paperwork with you for your first appointment on: _____ at _____ in our Valparaiso / DeMotte office. Please arrive 15 min prior to your appointment.

Please bring a photo I.D., form of payment and your current health insurance card(s). All co-pays and deductibles are due at the time of service. We accept cash, check, or credit cards. (3% processing fee for credit/debit card)

Bring any **shoes and old arch supports** associated with exercise. Please avoid creams, lotions, or perfumes prior to your appointments.

It is also important to bring any recent x-rays, MRI, CT, Ultrasounds, and reports which are related to the problem for which you are coming to our clinic. You may need to call the facility where the testing was done to obtain copies needed to bring to your appointment with Dr. Sommer. It is always a good idea to give the facility 24-48 hours notice prior to picking up your records.

Please feel free to call our office if you have any other concerns or questions at: 219-477-Foot (3668)

We look forward to serving you and your foot care needs.

Sincerely,

Dr. Paul Sommer and Staff

Paul Sommer DPM

PATIENT INFORMATION

Please complete all lines

DATE: _____

Name: _____ Age: _____Birthdate: _____

Address: _____City: _____St: ____ Zip Code: _____

Social Security Number: _____Sex: _____ Marital Status: S☐ M☐ D☐ W☐

Shoe Size and Width: _____ Approximate Weight_____

Home Phone: _____Cell Phone: _____

Pharmacy: _____Location: _____ Phone: _____

E-Mail Address: _____
(This is used for credit card receipts and the info is never shared)

Occupation: _____Employer: _____

Employer's Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Nearest Relative Not at Your Address: _____Phone: _____

Spouse Or Parent's Name: _____Phone: _____

Insurance Information (We will need a copy of your insurance card)

Insurance Co: _____

Guarantor: _____Birth date: _____

Guarantor Social Security Number: _____

Guarantor's place of employment: _____

Family Doctor: _____Phone: _____

Former Podiatrist: _____

What did that Podiatrist treat you for? _____

What condition brings you to the office today? _____

_____

How were you referred to this office? (Check All That Apply)
1. Doctor ☐. Family/friend ☐. Friend☐ Yellow Pages /Google☐. Sign ☐

6. Website ☐. Health Fair ☐. Facebook☐. Insurance network☐ Hospital☐

Whom may we thank for referring you? _____

Paul Sommer DPM

Please Check "Yes" or "No"

Are You in Good Health? ☐ Yes ☐ No

Have you been Under a Doctor's Care in the Past Year? ☐ Yes ☐ No

Have You Ever Had Any Broken Bones of the Foot/Leg/Hip ☐ Yes ☐ No

Which Bones and When? _____

Have You Ever Had Any Foot Surgery ☐ Yes ☐ No

What Surgery and When? _____

List All Other Surgeries You Have Had: _____

_____

Have You Ever Had Any of The Following? (**Please check all that apply**)

Diabetes ☐ High Blood Pressure ☐ Bleeding Problems ☐ Healing Problems ☐ Foot Ulcers ☐

Foot Infections ☐ Circulation Problems ☐ Arthritis ☐ Liver Disease ☐ Lung Disease ☐

Heart Disease ☐ Kidney Dise ☐ Tuberculosis ☐ Epilepsy ☐ AIDS ☐ Cancer ☐ Asthma ☐

Chemical Dependenc ☐ Psoriasis ☐ Stroke ☐ Athlete's Foot ☐ Back Pain ☐ Neuropathy ☐

Do you smoke? ☐ Yes ☐ No How much and how long? _____

"I hereby give permission to Dr. Paul Sommer and staff to administer treatment and to perform such procedures as may be necessary in the diagnosis and treatment of my condition. I authorize release of information necessary to process my insurance claims. I authorize the photography and/or x-ray of my feet for medical records. I authorize payment of medical benefits to Dr. Paul Sommer for services rendered. We participate with many but not all commercial insurance carriers. We will bill all insurance carriers on your behalf. We will be your advocate but ultimately all charges remain the responsibility of the patient and are due within 60 days from the date of service. Patients who are covered by insurance plans in which we do not participate must pay the out of network benefits at the time of service. The **entire unpaid balance regardless of the benefits and payment policy of your carrier is due in 60 days.** Please be your own consumer advocate because ultimately your insurance coverage is a contract between you and your insurance provider.

If it becomes necessary to turn my account over to collections, I will be fully responsible for all fees, including reasonable attorney fees incurred therein."

"**I fully understand that payment for all services is due on the day that services are rendered including insurance co-pay and deductible**."

"I understand that failure to meet appointments without 24-hour notice will result in a $35 surcharge."

Signature of Patient: _____

or Legal Guardian: _____

Date: _____

Family Foot & Ankle Clinic

www.familyfoot.com 477- Foot (3668) Paul Sommer, DPM, FACLES

Patient's Name: _____

Date of Birth: _____ Date: _____

Please fill this out completely and accurately on *THIS FORM* and bring it with you to your appointment.

MEDICATIONS	**VITAMINS AND/OR SUPPLEMENTS**	DOSAGE	WHEN WAS MEDICATION STARTED?	PRESCRIBING DOCTOR	***EMPLOYEE'S INTIALS***	***DATE CK'D***

Are you allergic to any medications: (Please list here)?

_____

_____

By the signature below, I acknowledge that I have received, read, and understand the:

"NOTICE OF PRIVACY PRACTICE: OUR COMMITMENT TO YOUR PRIVACY" policy form of **Family Foot and Ankle Clinic**, and that this signature will be kept in patient's file.

Patient Name: (print)_____

List individual names with which we may discuss your medical and/or financial information (other than Healthcare providers.)

1. _____
2. _____
3. _____
4. _____

Signature of legally responsible party: _____

Date: _____

OR: I **refuse** to accept/sign the above notice of privacy

Signature: _____ Date: _____

FAMILY FOOT AND ANKLE CLINIC
PAUL SOMMER DPM

CANCELLATION POLICY

Thank you for choosing Family Foot and Ankle Clinic for your healthcare needs. When you schedule an appointment with Dr. Sommer, we reserve this time slot for you to be seen. Should you need to cancel or reschedule this appointment, please call the Valparaiso office at (219) 477-3668 or DeMotte office at (219) 987-2700, as soon as possible. We will try accommodating your needs to the best of our ability.

Due to the large number of patients and our high standard of care, notify us if you will be more than 15 minutes late, as we may have to reschedule your appointment. Notify us of cancellations or reschedules at least 24 hours in advance. Failure to do so may result in a $35.00 charge.

Please review the above information and sign below. Your signature indicates that you understand this policy and agree to abide by it.

Print name: _____ Date: _____

Signature: _____