817-424-FOOT (3668) **www.texasfootdoctor.org**

Referring Doctor: _____

Patient Name: _____ Date of Birth: ____/_____/_____
First Middle Last

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Address :_____
Street City State ZIP

Social Security #_____ D.L. #_____STATE_____

Marital Status: _____ Gender: ☐M ☐F

Pharmacy & Phone #: _____
Name Location Phone Number

How did you find out about our office? Friend_____, Insurance company, Drove by, Movies, Newspaper, Doctor

_____, Other _____

Insured Employer Name:_____Phone #_____
Employer
Address:_____
Street City State ZIP

1) If today's visit is related to an injury at work please check:☐
2) Have you notified your employer?☐Yes☐No
3) Please give a brief description of the injury and date it happen? _____

If the patient is under 18 years old**. Guardian Name**:_____
Name Date of Birth

Address :_____
Street City State ZIP Phone

INSURANCE INFORMATION

Primary Insurance: _____
Insurance Company Name **Phone #** **Member ID Number**

Your relationship to the policy holder:☐Self ☐Spouse ☐Child **Policy holders Name**: _____

Secondary Insurance: _____
Insurance Company Name **Phone #** **Member ID Number**

EMERGENCY CONTACT INFORMATION

Name Phone# Cell #

I certify this form has been completed accurately and to the best of my knowledge.

Print Full Name Signature Date

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Please thoroughly read each ACADEMY FOOT & ANKLE SPECIALISTS policy, initial next to each policy and sign below:

Treatment Agreement

____ I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

Release of Information

____ For the purpose of payment, I allow ***Academy Foot & Ankle Specialists*** to release my Private Health Information to any and all of my insurance carriers, their third party payors and claim reviewers, until the claim is resolved. For the purpose of treatment, I also allow the above listed practice to release my information or contact any and all of my treating physicians. List any additional individuals you wish to have access to your medical and billing information: _____

_____

Contact Methods

_____ For the purpose of keeping you informed Academy Foot & Ankle Specialists uses Athena Health to contact patients by phone, text or email on our behalf.

Photograhs/Video Release

I __ **do** or __ **do not** authorize Academy Foot & Ankle Specialists to use clinical photographs and videos for educational or promotional purposes.

Academy Foot & Ankle Specialists: Doctors Invested in your care

____ Many of our physicians at Academy Foot & Ankle Specialists have financial interests in facilities/medical companies in north Texas. These facilities and our physicians are committed to providing clinical excellence to our patients in a safe high quality environment. Their financial interest in these facilities often provides them a voice in administration and in clinical and operational policies. This involvement helps to ensure the highest level of patient care and customer service. Patients of Academy Foot & Ankle specialists always have the option of utilizing an alternative healthcare facility. Please ask one of our representatives for an alternate facility. The following is a list of facilities/medical companies one or more of our physicians have a financial interest in: Local Hospitals, surgical centers, Imaging facilities, Pharmacies, laboratories, Physical Therapy facilities, supply companies, research laboratories, etc.

Acknowledgement of Receipt of Notice of Privacy Practices

____ I acknowledge that I was provided a copy of the HIPAA Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice. The ACADEMY FOOT & ANKLE SPECIALISTS HIPAA rights are also posted in lobby and at www.texasfootdoctor.org.

Patient Financial Policy

____ You must provide personal (address, phone numbers, etc) and/or insurance changes (carriers, networks, id numbers, etc) to the office at least 2 days prior to your appointment. In the event the office is not informed, you will be responsible for any charges denied.

____ You are responsible for all authorizations/referrals/precerts needed to seek treatment with ACADEMY FOOT & ANKLE SPECIALISTS physicians. If you are unsure if your referral or precert is current please check with one of our representatives.

____ Your portion of payment for ALL office services is due **at the time of service**. We will accept VISA, MasterCard, cash or check. All benefit quotes or prices given are merely an estimate and are not a guarantee and are subject to change, based on your insurance carriers determination, there may be an additional balance due.

____ Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you with an assignment of benefits. You are agreeing to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, the patient or guardian seeking care for a minor, will be responsible for payment of services. You are encouraged to contact your designated patient account representative at our office with any questions.

____ Please honor our 24 reschedule notice, as there may be a charge for appointments broken or cancelled without 24 hours advanced notice. Repetitive broken or cancelled appoints and/or non-compliance may result in transfer of your care to an alternative practice.

____ We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will require you to pay the co-pay/co-insurance/deductible at the time of service. Your upfront portion will be calculated based on your insurance benefit/limits and our negotiated fee agreement with your carrier. If you are seeing our doctors on an 'Out of Network" basis, you will be subject to out of network rates. Once the claims are

processed by your insurance there may be an additional balance we will bill you for this amount.

____ Not all services are a "covered" benefit in all insurance policies; some plans even impose a waiting period before covering services. In the event your health plan determines a service to be "not covered/pre-existing," or you do not have an authorization, you will be responsible for all charges. We will attempt to verify benefits for some specialized services; 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.

____ Our office **does not** file to **tertiary insurance**. For all other insurances, we will provide an itemized statement upon your request. If you possess two insurance plans, you MUST notify us of your designated PRIMARY policy.

____ Pre-scheduled Surgical procedures require pre-payment/estimated deposit. Your deductible/co-insurance/co-pay for this procedure is due at the pre-operative appointment. For other services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

____ We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Any payment exceptions will be agreed upon in writing. We are happy to discus repayment options.

____ PAST DUE accounts are subject to collection proceedings including the credit bureau. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

____ Accounts no longer maintaining a financial "Good Faith" status will result in the termination of the Academy Foot & Ankle Specialists Doctor-Patient relationship.

____ There is a service fee of $25.00 for all returned checks. Upon an NSF or CLOSED ACCOUNT occurrence, all future remittances will need to be in other forms of payment. Restitution of "Theft-by-Check" will be requested from the District Attorney's Office.

____ ACADEMY FOOT & ANKLE SPECIALISTS issues patient refunds by credit card or check within 90 days of a completed investigation of the potential overpayment. Refunds are made once all dates have been paid in full by the insurance or patient.

____ ONLY UNWORN and NON-custom items are returnable within 3 days of receipt. Custom items are non-returnable.

____ Medical Records and X-Rays are the property of the office. We can make arrangements for you to get a copy with 30 days notice. X-rays are $10.00 per film per copy. Medical records are $2.50 per page per copy. These charges are not covered by your insurance and all requests should be made in writing.

____ Disability forms or work forms that need to be completed by our office will incur a charge of $10.00 per form per occurrence.

____ Minor Patients if unaccompanied non-emergency treatment will be denied unless appropriate consent has been received and charges have been pre-authorized.

Authorization of Payment

____ I hereby assign all Medical benefits directly to ***Academy Foot & Ankle Specialists*** for the payment of any services rendered. I also authorized release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay for the services I received, I will be financially responsible for payment.

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

Patient's Name: _____ Signature of Patient/Guardian: _____ Date: _____

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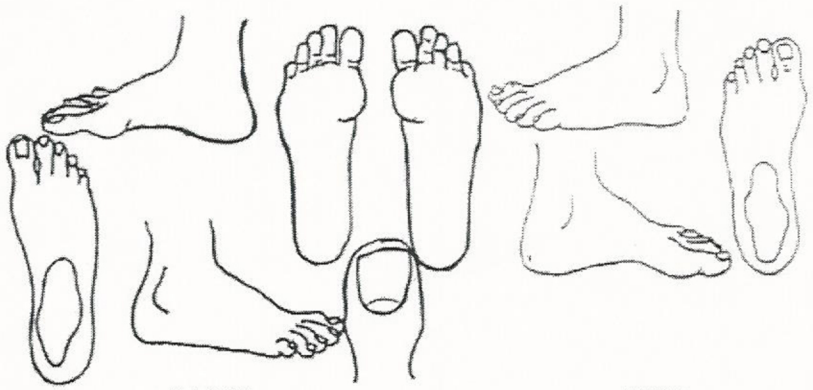
Patient History Form

Please fill out the following confidential form for our records. Please indicate where you feel pain on the foot and ankle diagram below.



RIGHT LEFT

Patient name: _____

Age:_____ Race:_____ Gender:_____ Height: _____Weight: _____Shoe size:_____

Current foot or ankle problem:

_____

Nature (Sharp, Dull Achy, Burning, Etc): _____

Location (Where Is The Pain): _____

Duration (How Long Have You Had The Problem): _____

Onset (What Happened?, New Activities, New Shoes, New Job, Accident,etc): _____

Course(Intermittent, Constant, Progressive):_____

Aggravates (What Makes The Pain Worse?, Standing,Sitting, Not Wearing Shoes, Climbing,Etc): _____

Treatment (What Has Been Done and Did It Help?) _____

REVIEW OF SYSTEMS

Do You Currently Wear Eyewear? (Glasses Or Contacts) ☐ Yes Or ☐ No

MEDICAL HISTORY

Do you or have you had any of the following medical conditions:

- ☐ Acne
- ☐ Anemia/sickle cell
- ☐ Arthritis
- ☐ Artificial joint replacement
- ☐ Asthma/bronchitis
- ☐ Basal Cell
- ☐ Bleeding disorders
- ☐ Cancer
- ☐ Cataracts
- ☐ Charcot Foot
- ☐ Charcot Marie Tooth Disease
- ☐ Depression or anxiety
- ☐ Diverticulitis
- ☐ Epilepsy/seizures
- ☐ Fibromyalgia
- ☐ GI bleeding/ulcers
- ☐ GI Reflux
- ☐ Gout
- ☐ Heart disease/heart attack
- ☐ Hepatitis A, B, or C
- ☐ Hernia
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Immune disease (HIV, AIDS)
- ☐ Insulin Dependent Diabetes Mellitus
- ☐ Kidney or bladder
- ☐ Liver disease
- ☐ Malignant Melanoma
- ☐ Melanoma
- ☐ Mitral Valve Prolapse
- ☐ Muscular Dustrophy/Muscular Disorders
- ☐ Non-insulin Dependent Diabetes Mellitus
- ☐ Pulmonary Fibrosis
- ☐ PVD
- ☐ Raynoud's Disease
- ☐ Rheumatoid Arthritis
- ☐ RSD
- ☐ Rosacea
- ☐ Squamous Cell
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Warts

List any other medical problems not listed above: _____

_____

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SURGERIES and HOSPITALIZATIONS: (describe procedure, year and any complications)

1) _____
2) _____
3) _____
4) _____

ALLERGIES: (aspirin, sulfa drugs, penicillin, iodine, novocaine, tape, foods, drugs, etc.)

1) _____ 3) _____
2) _____ 4) _____

Have you ever had a reaction to local or general anesthesia? ❒ Yes ❒ No

MEDICATIONS (Please include dosage of each. Include vitamins and supplements)

1) _____ 5) _____
2) _____ 6) _____
3) _____ 7) _____
4) _____ 8) _____

SOCIAL HISTORY

Occupation: _____

Do you spend most of your time standing, walking, heavy lifting, etc. _____

Disabled _____ Retired _____

Sports and Exercise _____

Tobacco: ☐ No ☐ Yes How much & what kind? _____ _____

Caffeine: ☐ No ☐ Yes How much & what kind? _____ _____

Alcohol: ☐ No ☐ Yes How much & what kind? _____ _____

Illicit drugs: ☐ No ☐ Yes How much & what kind? _____ _____

FAMILY HISTORY

List medical problems your parents have/had such as high blood pressure, diabetes, cancer, bunions, flatfeet, hammertoe, poor circulation, etc.

Mother ☐ Alive ☐ Deceased _____

Father ☐ Alive ☐ Deceased _____

Name of family physician _____ Date last seen (approx.) _____

Name of former podiatrist _____ Date last seen (approx.) _____

Whom may we thank for referring you to our office? _____

I hereby give Academy Foot & Ankle Specialists, permission to diagnose and administer treatment for my foot and ankle condition and authorize any release of information obtained in the course of my treatment.

Signature: _____ Date: _____