Welcome to Our Office!

Patient Name: _____ DOB: _____ Gender: **M / F** SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #:_____

Preferred number of contact**: (Circle one)** Home / Cell / Work

E-mail Address: _____ Marital Status: **(Circle one)** **S M D W**

Employed - **FT / PT** - Unemployed - Retried - Disabled Student - **FT / PT**

Parent or Person responsible for account: (If patient is a minor, under 18 years of age.)

Name: _____ DOB: _____ Phone #: _____

Address if different from above: _____ Relationship: _____

Should the patient be a minor, a legal guardian must be present at every appointment in order to have services rendered.

Emergency Contact: (Please include a phone number other than what is listed above)

Name: _____ Phone #: _____ Relationship: _____

Primary Care Physician Name: _____ Phone #: _____

Address: _____

How were you referred to our office? (Circle one)

My Doctor **Friend/Family** **Internet** **Through Insurance** **Drive By** **I am a Previous Patient**

Doctors Name: _____ Phone #: _____

Will you be using Insurance? (Circle one)

YES: Insurance Carrier: _____ ID# _____ Group#: _____

Policy Holder: _____ DOB: _____ Relationship _____

We DO NOT Back-file previous visits, therefore ALL INSURANCE INFORMATION MUST BE ACCURATE AND UP TO DATE. If your insurance has changed, please notify our office before your scheduled appointment otherwise, you will be responsible for services rendered.

NO: I will be Self Pay / Pay out of pocket

*For your convenience the office accepts all Major Credit Cards / Debit Cards, Cash, Checks and Care Credit

WE DO NOT ACCEPT WORKERS COMPENSATION INSURACE.

Patient / Guardian Signature _____ **Date**: _____

The above information is true to the best of my knowledge. I authorize Houston Foot Doctor to release any information required to process my claims.

Patient Clinical Information

Reason for visit: _____ When did it begin? _____

Have you seen another doctor for this? Yes / No If yes, who? _____

Was this problem caused by an accident or work related injury? **(Circle one)** Accident / Work Injury
We do not accept Worker Comp but will gladly provide you with necessary paper work to submit your own claims.

Occupation: _____ Does your job require for you to be on your feet more than 4 hours? Yes / No

Shoe Size? _____ Height: _____ Weight: _____

Smoking Status: **(Circle one)** Current Former Never **Drinking Status**: Yes / No

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Please list any medications you are allergic to or have had adverse side effects to.

_____

Please list any medications you are currently taking prescribed and over the counter*: (include dosage)

_____

_____

_____

*** The above medications are true and complete. Omissions are unintentional and will be corrected at my responsibility. Interactions caused by my omission, is not the responsibility of HFD.**

How would you like your prescriptions? (Circle one) **Print my prescription** **Send to my Pharmacy**

Pharmacy Name: _____ Phone #: _____

Address: _____ City: _____ Zip Code: _____

Please check any <u>previous and current</u> medical conditions.

___*ADD/ADHD*	___*Depression/Anxiety*	___*High Cholesterol*	___*Seizures*
___*Alzheimer's Disease*	___*Diabetes*	___*HIV Positive*	___ *Shortness of Breath*
___*Ankle Swelling*	___*DVT*	___ *Kidney Disorders*	___ *Stroke*
___*Asthma*	___*GERD*	___ *Liver Disorders*	___ *Thyroid Disorder*
___*Atrial Fibrillation*	___*Gout*	___ *Lung Disorders*	___*Ulcers*
___*Blood Clots*	___*Headache/Migraine*	___*Neuropathy*	
___*Cancer*	___*Hepatitis*	___*Parkinson*	
___*COPD*	___*High Blood Pressure*	___ *Poor Circulation*	

Other conditions not listed above: _____

_____

Past Surgical History: (Please include the year preformed) _____

_____

_____

Disclosure of Patient Protected Health Information

In general, the HIPPA privacy act gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner **(circle all that apply)**

Telephone

Leave a detailed message at: HOME CELL WORK

Written Communication

Mail to my home E-Mail Fax: # _____

Authorized PHI Recipients

Patient Only Spouse Parent Son/Daughter

Other: (name & relation to patient) _____

By signing this form you indicate that you have read and agree to follow the HIPPA Notice posted in our office as well as the Office Policy provided.

Patient / Guardian Name: _____ Date: _____

_____
Signature

OFFICE POLICY

Welcome to our office! Houston Foot Dr. has been serving the Houston area for over 30 years. Our Goal is to help your feet last a lifetime with as little or no pain as possible on a permanent basis.

Please take a moment to carefully review our policy and sign confirming you have read and understood our policy.

MEDICARE PATIENTS

If you have Medicare as your primary insurance and have a supplement insurance, please make sure Medicare is aware, as they will forward the claims to your secondary insurance. It may take up to 4-6 weeks for your secondary insurance to respond with payment or denial.

ALL PATIENTS

Our office will verify your benefits, however due to the variety of insurance plans, we have NO WAY of determining what your plan coverage will be or our physicians network status with your particular plan.. **WE DO NOT FILE SECONDARY INSURANCE CLAIMS**. Should you have a secondary insurance, we can provide you with all the necessary information so that you may file your claim.

ALL CHARGES INCURRED ARE DUE AND PAYABLE AT THE TIME OF THE VISIT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Our office will make every attempt to collect payment from your insurance company. However, any claims not paid by your insurance company within 60 days or in the event that your insurance denies a service or procedure, will become your responsibility. Please be advised that any unpaid or delinquent balances over **90 days** will be sent to an outside source for collection and a **35% collection fee** will be applied.

The federal government has informed us that we can be penalized for not collecting co-payments, deductibles, and coinsurance. Therefore, we will collect payments before services are rendered.

Requests for medical records/x-rays require 15 day notice. Fees will apply.

MISSED/CANCELLED appointments without 24 hour notice will be subject to a **$25 fee** for office visits and a **$50 fee** for office procedures.

I, _____, have read and fully understand the information above. I hereby give my permission for the doctor to render the proposed Podiatric examination and treatment. I understand that I am financially responsible to the physician for all charges incurred by me or my dependents. I authorize the provider to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason on my behalf and I will be active in the resolution of claim delays or unjustified reductions or denials.

Patient / Guardian Signature: _____ Date: _____

Thank you for your cooperation.

HFD STAFF ONLY

Witness: _____