



# Welcome Back!

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: **S M D W**

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

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

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ 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 #: \_\_\_\_\_

**(Check one)**

\_\_\_\_ My Insurance has not changed since my last visit to Houston Foot Dr – **Insurance Carrier:** \_\_\_\_\_

\_\_\_\_ My Insurance Carrier has changed - **Insurance Carrier:** \_\_\_\_\_ **ID#:** \_\_\_\_\_  
Please provide a copy of your new insurance card.

\_\_\_\_ I am not using insurance, will be self pay. (We accept all Major Credit Cards, Debit Cards, Checks, Cash, and Care Credit)

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

Shoe Size? \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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

**Please list any medications you are currently taking and the reason.\* (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 #: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Please check any previous and current medical conditions.**

- |  |   |  |   |  |
|--|---|--|---|--|
| <input type="checkbox"/> ADD/ADHD            | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Gout                | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Alzheimer's         | <input type="checkbox"/> COPD               | <input type="checkbox"/> Headache/Migraine   | <input type="checkbox"/> Liver Disorders  | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Ankle Swelling      | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Lung Disorders   | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neuropathy       | <input type="checkbox"/> Thyroid Disorder    |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> DVT                | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Parkinson        | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> Blood Clots         | <input type="checkbox"/> GERD               | <input type="checkbox"/> HIV Positive        | <input type="checkbox"/> Poor Circulation |  |

Other conditions not listed above: \_\_\_\_\_

**Past Surgical History:** (Please include the year preformed) \_\_\_\_\_

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**Patient / Guardian Signature** \_\_\_\_\_

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.

## OFFICE POLICY

**Welcome back 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.**

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### 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 about 4-6 weeks for your secondary insurance to correspond 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.