FOOT & ANKLE CENTER OF DALLAS

Patient Name: ___________________________________ **Date of Birth:** _____________ **Sex:** ____M____F

Address:____
Street *Apt. #* *City* *State* *Zipcode*

Home # ________________________ **Work #** _________________________ **Cell #** ______________________

Email:____ **Preferred Method of Contact:** ______________________

Emergency Contact Name/Relation: _____________________**Emergency Phone:** ____________________________

Primary Language: __________________ **Employed:** ____Y____N **Occupation:** __________________________

Ethnicity: _______________________ **Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partner

PRIMARY CARE PHYSICIAN ****Must be a doctor of Family Medicine/ Primary Care/ Internal Medicine/Endocrinology***
Name: ____

Primary Care Physician Phone # _____________________________________ **Date Last Seen:** _______________

PLEASE NOTE: MEDICARE RELATED INSURANCES REQUIRE A PRIMARY CARE PHYSICIAN BE LISTED FOR CERTAIN SERVICES TO BE PAID.

HOW DID YOU HEAR ABOUT US?
☐ Physician ☐ Internet/Google Search ☐ Insurance ☐ Family/Friend ☐ Kroger ☐ Facebook/Instagram
☐ Other: ____

☐ **SELF-PAY/ NO INSURANCE**

INSURANCE INFORMATION

PRIMARY INSURANCE: ____ Employer: ______________

Policy Holders Name: ____Social Security # ___________________

Policy Holders Date of Birth: _________________________Relationship to Policy Holder: ______________________

SECONDARY INSURANCE: ____ Employer: ______________

Policy Holders Name: ____Social Security # ___________________

Policy Holders Date of Birth: ________________________Patient Relationship to Policy Holder: _________________

EXPLANTION OF PAYMENT POLICY & PRIVACY POLICY

I hereby authorize Foot & Ankle Center of Dallas to release my medical information pertinent to the filing of insurance claim s for me. I authorize my insurance carrier to pay benefits directly to Foot & Ankle Center of Dallas on any unpaid services filed on my behalf. I understand that I AM RESPONSIBLE for payment to Foot & Ankle Center of Dallas for charges for the above patient regardless of my insurance coverage. I also understand that Foot & Ankle Center of Dallas is not ultimately responsible for collecting my insurance or negotiating settlements of claims. I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have had the opportunity to read and understand the Notice. I also hereby give the Foot & Ankle Center of Dallas permission to diagnose and administer treatment for my foot and/or ankle condition and authorize any release of information obtained during the course of my treatment.

Patient Signature: ____ **Date:**______________

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Patient Name: ____ **Shoe Size:** ____________________

Reason for Visit: ____ **Pain Level:** ___________

Alcohol Intake: _____________________________ **Caffeine Intake:** ____________________________

Smoker: ☐ Y ☐ N **Pack(s)/Day**_____ **Years Previous Smoker:** ☐ Y ☐ N **How Much/long:** ________

Height: ___________ **Weight:** _____________

CONSTITUTIONAL: Are you currently experiencing? ☐ Nausea ☐ Vomiting ☐ Fever ☐ Chills ☐ Night Sweats

Date of Last FLU Vaccine: ____________ **Pneumonia Vaccine:** __________ **COVID Vaccine:** _________

PREFERRED PHARMACY: ______________________________ **PHARMACY PHONE:** _______________
Pharmacy Location/Address: ____

MEDICATIONS: List of Current Medications & Dosage: ____
____
____

PAST MEDICAL HISTORY: If you have or have had any of the following conditions- Please check ALL that apply.

☐ Athlete's Foot	☐ Dementia	☐ HIV/AIDS	☐ Osteoarthritis
☐ Atrial Fibrillation	☐ Depression	☐ Heart Attack	☐ Osteopenia
☐ Bipolar Disorder	☐ Diabetes I	☐ Hepatitis B	☐ Osteoporosis
☐ Bleeding Disorder	☐ Diabetes II	☐ Hepatitis C	☐ Pacemaker
☐ Blood Clots	☐ Dialysis	☐ High Blood Pressure	☐ Peripheral Arterial Disease (PAD)
☐ Congestive Heart Failure	☐ Eczema	☐ High Cholesterol	☐ Peripheral Vascular Disease (PVD)
☐ COPD	☐ Endocrine Disorder	☐ Immune Disease	☐ Psoriasis
☐ Cancer	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatoid Arthritis
☐ Coronary Attery Disease	☐ Fibroid Tumor	☐ Lupus	☐ Seizures
☐ Crohn's Disease	☐ GERD	☐ Lymphedema	☐ Stroke
☐ Currently Pregnant	☐ Glaucoma	☐ Nail Disease	☐ Thyroid Disease
☐ Deep Vein Thrombosis (DVT)	☐ Gout	☐ Neuropathy	☐ OTHER: ___________________

MEDICATION ALLERGIES/ REACTION: ☐ YES ☐ NO
If YES, Please List Medication your Allergic to: ____
____

FAMILY HISTORY: Please check mark any medical conditions that run in your family and write which member(s) are affected.
☐ Diabetes: __________ ☐ Gout:__________ ☐ Heart Disease:_________ ☐ Circulation Problems: _________
☐ High Cholesterol: ___________ ☐ High Blood Pressure: ___________ ☐ OTHER: ___________________

SURGERIES: List all surgeries you have had. Begin with the most recent. Please provide year.
____
____

FOOT & ANKLE CENTER OF DALLAS

Your understanding of our financial policies is an essential element of your care & 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 accept VISA, Mastercard, Discover, 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 your insurance benefits to the Foot & Ankle Center of Dallas. In other words, you agree to have your insurance pay the Foot & Ankle Center of Dallas/Dr. Brandon Lampe, DPM directly. If your insurance company does not pay the Foot & Ankle Center of Dallas/ Dr. Brandon Lampe within **60 days,** you will receive a bill.
- 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 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.
- 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 or at the time of your Pre-OP appointment,
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to collections fees, attorney fees, and court fees shall be your responsibility in addition to the balance due to Foot & Ankle Center of Dallas/ Dr. Brandon Lampe, DPM.
- Patients who are **90 days** past due on their balance will be sent to collections- unless you have an authorized payment plan put into place.
- There is a service fee of **$25.00** for all returned checks. Your insurance company does not cover this fee.
- In fairness to all our patients, we understand that emergencies occur, but repeated No-Shows or cancellation(s) with **less than 24-hr notice** will result in a **$25.00 fee**. You may be asked to pay before you are seen by Dr. Brandon Lampe, DPM.
- Patients who arrive to our office **15-minutes late** to their scheduled appointment might be asked to reschedule.

Print Name of Patient/ Responsible Party: ______________________________________ Date: _________

***Signature of Patient/ Responsible Party:* ____________________________________ Date: __________**

HIPPA COMPLIANCE PATIENT CONSENT FORM

The HIPPA (Health Insurance Portability & Accountability Act of 1996) law allows for the use of the information treatment, payment, or healthcare operations. You have the right to restrict how your protected health information is used and disclosed for treatment and payment of healthcare operations. The terms of this notice may change. If so, you will be notified at your next visit to update your signature and date.

By signing this form, you consent to our use and disclosure of your protected healthcare information according to the indications below.

- Protected health information may be disclosed or used for treatment, payment and or healthcare operations.
- The privacy policy may be changed by practice, when necessary, as required or allowed by the law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The privacy policy will stay in effect until the time that it is revoked by our patient or changed as required by the law.

PLEASE INDICATE YOUR PREFERNCES REGARDING YOUR PERSONAL HEALTHCARE INFORMATION. Please check ✓mark preferred notification reminders.

Health Notifications:	______ Email	_______ Phone	_______ Text Message
Auto Appointment Reminders:	______ Email	_______ Phone	_______ Text Message
Practice Announcements:	______ Email	_______ Phone	_______ Text Message
Billing Information:	______ Email	_______ Phone	_______ Text Message

Please provide the phone number and/or e-mail you would like to use for office reminders:

____

May we discuss your medical condition with a family member? ______ Yes ______ No

If YES, please list the Name of the authorized family member allowed to have access to your medical records.

Name: ____________________________________ Relationship to Patient: ________________

Name: ____________________________________ Relationship to Patient: ________________

Print Patient Name: ____ Date: _______________

Signature of Patient: ____ **Date:** _______________