The Foot and Ankle Center of Dallas

First Name:_____ Last Name_____ Date of Birth: _____ Sex:___ M ____ F

Address:_____ _____ _____ _____ _____
Street Apt # City State Zip

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

Email:_____ Social Security #_____-_____-_____

Emergency Contact:_____ Emergence Phone:_____

Emergency contacts relationship to the Patient:_____

Primary Language:_____ Do you need a translator: Y N

Employed:___Y____N Occupation:_____

Ethnicity:_____ Marital Status (circle): Married Single Divorced Widowed Partner

Primary Care Physician ** must be a doctor of Family Medicine, Primary Care, Internal Medicine, Endocrinology

Name:_____ Date Last Seen:_____

Primary Physician Phone:_____

(PLEASE NOTE: Medicare related insurances require that a Primary Care Physician be listed for certain services to be paid)

HOW DID YOU HEAR ABOUT US? (circle)

Physician Internet Google Insurance Friend Family Magazine Grocery Ad Social Media Mall Ad Healow

Other___

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ID #:_____

Policy Holders Name:_____ Social Security #:_____

Policy Holders Date of Birth:_____ Patient Relationship to Policy Holder:_____

SECONDARY INSURANCE

SECONDARY INSURANCE NAME: _____ID #:_____

Policy Holders Name:_____

EXPLANATION OF PAYMENT POLICY & PRIVACY POLICY

I HEREBY AUTHORIZE Foot & Ankle Center of Dallas to release medical information pertinent to the filling of insurance claims 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 the Foot & Ankle Center of Dallas for charges for the above patient regardless of my insurance or negotiating settlements of claims. I acknowledge that I was provided 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 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's Signature:_____ Date:_____

Foot & Ankle Center of Dallas

Patient Name:_____ **Shoe Size:**_____

Reason for your visit:_____ **Pain Level:**_____

Alcohol Intake:_____ **Caffeine Intake:**_____

Smoker Y/N:_____ **pack(s)/ day X** _____ **years Previous Smoker : YES NO How much/Long:**_____

Height:_____ **Weight:**_____

Constitutional: Are you currently experiencing (please circle): Nausea Vomiting Fever Chills Night Sweats

Date of Last Flu Vaccine: _____ **Pneumonia Vaccine:**_____ **COVID Vaccine:**_____

Preferred Pharmacy: _____ **Pharmacy Phone :**_____

Pharmacy location/address:_____

Medications : List 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
☐ Congestive Heart Failure	☐ Eczema	☐ High Cholesterol	☐ Peripheral Vascular Disease
☐ COPD	☐ Endocrine Disorder	☐ Immune Disease	☐ Psoriasis
☐ Cancer	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatoid Arthritis
☐ Coronary Artery Disease	☐ Fibroid Tumors	☐ Lupus	☐ Seizure
☐ Crohn's Disease	☐ GERD	☐ Lymphedema	☐ Stroke
☐ Currently Pregnant	☐ Glaucoma	☐ Nail Disease	☐ Thyroid Disease
☐ Deep Vein Thrombosis	☐ Gout	☐ Neuropathy	☐ OTHER_____

Drug Allergies: YES NO If yes, please list:

_____

_____

Family History: Please circle any medical conditions that run in your family and write each member (s) effected.

Diabetes _____ **Gout**_____ **Heart Disease**_____ **Circulation Problems**_____ **High Blood Pressure**_____

High Cholesterol_____ **Other** _____

Surgeries: List all surgeries you have had. Begin with the most Recent. Please give year:

_____

_____

If Diabetic, who handles your diabetes?_____**Phone #**_____

Last A1C?_____ **Date Performed:**_____ **Preformed By:**_____

The Foot and Ankle Center of Dallas

Your understanding of our financial policies is an essential element of your care and 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 is due at the time of service. We accept Visa, MasterCard, Discover, American Express, Apple Pay, 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 have assigned the benefits to the doctor (in other words, if you have agreed to have your insurance company pay the doctor directly), but your insurance company does not pay the practice within 60 days, you will receive a bill.

• All insurance plans differ, and not all services are covered. If your health plan determines a service to be "not covered" or if there is no authorization, you will be responsible for the full charges. We will attempt to verify benefits for services or referrals; however, you remain responsible for any charges incurred for services rendered. Patients are encouraged to contact their health plans for clarification of benefits prior to receiving services.

• You must inform the office of any insurance changes and authorizations/referral requirements. In the event the office is not informed, you will be responsible for any charges denied by your insurance.

• For certain elective surgical procedures, we require prepayment. You will be informed in advance if your procedure falls into this category. 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 during this process, including but not limited to collection fees, attorney fees, and court fees, shall be your responsibility in addition to the balance due to the office.

• Patients with balances more than 90 days past due will be sent to collections unless a payment plan has been established.

• There is a $25 service fee for all returned checks, which is not covered by your insurance company.

• In fairness to all our patients, we understand that emergencies occur, but repeat no-shows or cancellations with less than 24-hour notice will result in a $50 fee. You may be asked to pay this fee before your next appointment.

• Patients who arrive more than 15 minutes late to their scheduled appointment may be asked to reschedule.

Signature of patient/Responsible Party:_____Date:_____

Printed Name of patient/Responsible Party:_____Date:_____

HIPPA COMPLIANCE PATIENT CONSENT FORM

The HIPPA (Health insurance portability and accountability act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or health 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 or healthcare operations.
- This privacy may be changed by the proactive, when necessary, as required or allowed by law.
- The Patient has the right to revoke this consent in writing at any time and all full disclosure will then cease.
- This privacy policy will stay in effect until the time that it is revoked by the patient or changed as required by law.

PLEASE INDICATE YOUR PREFERENCES REGARDING YOUR PERSONAL HEALTCARE INFORMATION:

Health notifications: _____ E-MAIL _____ PHONE _____TEXT MESSAGE

Auto Appointment Reminders: _____ E-MAIL _____ PHONE _____TEXT MESSAGE

Practice Announcements: _____ E-MAIL _____ PHONE _____TEXT MESSAGE

Billing Information: _____ E-MAIL _____ PHONE _____TEXT MESSAGE

Please indicate the phone number and /or e-mail you would like to use below:

_____

May we discuss your medical condition with a family member? _____YES _____NO

_____ Relationship to Patient _____

_____ Relationship to Patient _____

I consent to have my medical records shared with other Foot and Ankle Centers of Dallas Providers.

_____YES _____NO- Only upon request

I consent to have medical records shared with my care providers outside of the Foot and Ankle Center of Dallas.

_____YES _____NO- Only upon request

This consent was signed by:_____

(PRINTED NAME PLEASE)

Patient or Guardian Signature :_____Date:_____