Welcome To Caring Foot and Ankle Specialists

Patient Information:

Name_____ **Date**_____

Address _____**City/State**_____**Zip**_____

Home# _____**Work #**_____ **Cell #** _____

E-mail _____

Social Security # _____ **Date of Birth**_____ **Age**_____

Gender: M or F **Marital Status: S M D W** **Spouse**_____

Your Employer _____ **Address**_____

Primary Care Doctor Name: _____ **Phone#** _____

Address _____

Insurance Subscriber Information:

Name _____ **Date of Birth** _____

Social Security #_____-_____-_____ **Relationship to Patient** _____

Employer _____ **Phone #** _____

Emergency Contact: (Someone who is not living with you)

Name: _____**Phone #** _____

Whom May We Thank For Referring You?_____

Our office has a 24 hr cancellation and late arrival policy.
Failure to notify our office 24 hrs in advance of missing an appointment will result in $25 No-Show Fee.

Also, if you are more than 20 minutes late to your appointment time, you may be asked to reschedule your appointment, or wait until after punctual patients have been seen.

These policies are designed to decrease the overall wait-time for all patients by encouraging patients to be courteous and punctual. The most common reason for extended wait times are patient related.

We apologize for any inconvenience regarding these policies, and appreciate your understanding

By signing below you authorize Caring Foot and Ankle Specialists and their agents to provide any insurance company, claim administrator, and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits. I hereby authorize payment directly to Caring Foot and Ankle Specialists and their providers of the benefits otherwise payable to me. Also I hereby give permission to Caring Foot and Ankle Specialists Providers and their assistants to diagnose, administer medications, and perform such procedures as may be deemed necessary in the diagnosis/treatment of my foot and ankle related conditions. I understand and agree that because of human variance and response it is not possible to warrant the outcome of any medical care or service.

Responsible Party Signature _____

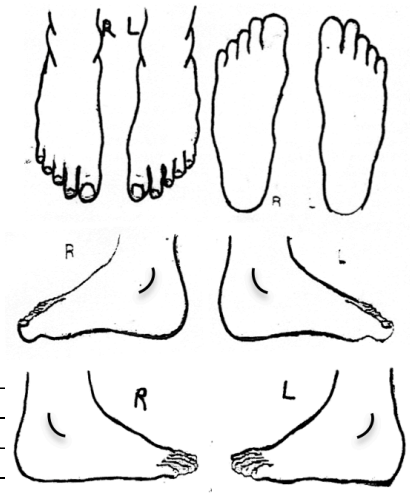
Relationship_____ **Date** _____

Name: _____ **Date of Birth:**___/__/__ **Appointment Date:**___/___/___

Reason for Visit: *(Please be as specific as possible)*

_____

_____



Location: *please mark areas of specific area of concern on the diagrams* →

Amount of pain: on 1-10 scale; 10 being worst pain: ___ /10

(Please be specific by circling all that apply)

Nature of pain: Dull, Sharp, Shooting, electric, Tingling, Itching, Burning
Duration: Constant, Intermittent, Flare-ups *(how often? _____)*
Onset of Symptoms: ____ days, ___ weeks, ____years ago
Date of initial injury: ___/___/____
Location of injury: home, work, automobile, other:_____
What makes the pain worse?: walking, weight-bearing, after rest, _____
_____
Treatments already tried:_____
Shoe Size: ____, *Men's/Women's/Wide/Narrow*

Primary Medical Doctor: _____ **Date of Last Visit:** _____/_____/_____

Doctor Treating for Diabetes: _____ **Date of Last Visit:** _____/_____/_____

Former Podiatrist: _____ **Date of Last Visit:** _____/_____/_____

MEDICAL HISTORY *(Please Circle only those items that apply)*:

Alzheimer's / Dementia
Anemia
Anxiety / Depression
Arthritis: Rheumatoid / Osteoarthritis / Lupus / Gouty
Artificial Heart Valves or Joints
Asthma / Emphysema / Lung Problem
Autoimmune Disease / HIV / AIDS
Back Problems / Herniated Discs
Blood Disease / Bleeding Disorders
Blood Clots / DVT
Broken Bones in Feet / Legs
Cancer – Type_____
Charcot Joint
Chemical Dependency – Type____
Chronic Diarrhea
Circulatory Problems
Cramps in feet or legs
CVA (Stroke) / TIAs
Diabetes: Diet / Oral / Insulin __# Yrs
Epilepsy / Fainting / Seizures
Fibromyalgia – Chronic pain disorder
Gastric Reflux / Hiatal Hernia
GI Ulcers / Stomach Problems
Gout
Heart Attack / MI
Heart Disease / Angina / Chest Pain
High Blood Pressure
High Cholesterol
Joint Replacements: Knee / Hip
Kidney Disease / Dialysis
Liver Disease / Hepatitis / Jaundice
Lyme's Disease
Neuropathy / MS
Osteoporosis
Peripheral Vascular Disease
Rheumatic Fever
Skin Problems / Psoriasis
Thyroid Problems / Hypothyroidism
Varicose Veins
Weight Loss / Gain (Unexplained)
If over 65 – History of Falls

Other Medical Problems *(Please List)*: _____

PAST SURGICAL HISTORY (*Please Circle only those items that apply*): NONE

Foot surgery: Type _____ **Date:** ___/___/_____ **Right or Left (Please Circle)**
Surgeon name: _____

Other Surgeries:

Amputation
Angioplasty or Stenting
Appendectomy
Arterial Bypass
Back Surgery
Breast Biopsy / Lumpectomy
C-Section
Cataract Surgery
Carotid Artery Surgery
D & C
Gall Bladder Removal
Heart Bypass Surgery
Hernia Repair
Hip Joint Replacement
Hysterectomy
Kidney Stones
Kidney Removal
Knee Replacement
Mastectomy
Other Joint Replacement
Pacemaker
Plastic Surgery
Prostate Surgery
Tonsillectomy
Venous Ligation
Wound Care

Other unlisted surgery: _____

Name: ___________________________________ **Date of Birth:**___/__/__ **Appointment Date:**___/___/___

<u>**Medications**</u> **(Please List — Include Non-Prescription Medications):** **NONE**

Drug Name	*Dose*	*Times taken per day,*	*Prescriber*

Pharmacy: ___________________ Address: ______________________ Phone: ______________ Fax: _____________

FAMILY HISTORY (Please circle if positive)

	Arthritis	**Diabetes**	**Heart Disease**	**Cancer**	**High Blood Pressure**
Mother	yes	yes	yes	yes	yes
Father	yes	yes	yes	yes	yes
Siblings	yes	yes	yes	yes	yes

Personal or Family History of Blood Clots? Yes / No **Details:** _______________________________

SOCIAL HISTORY *(Please Circle those items that apply):* **NONE**

Alcohol use: Yes or No, _________ # of drinks per Week. Past History of Alcohol Abuse: Yes or No
Tobacco use: Yes or No, _________ # of packs per Day _____ # of years smoking
Recreational Drug use: Yes or No, Past IV drug use: Yes or No
Sport or Exercise Activities: ____

ALLERGIES (Circle only those items that apply): ***No Known Drug Allergies***

Novocain	**Adhesive Tape**	**Motrin / Advil**
Aspirin	**Latex**	**Cortisone**
Codeine	**Iodine**	**Sulfa**
Penicillin	**Neosporin**	**Other:** ____________________________________

****

REVIEW OF SYSTEMS - Have you <u>currently</u> have any of the following Symptoms or Problems?

Head & Eyes:	Dizziness / Fainting / Headaches / Double Vision / Infection
Ear Nose or Throat:	Difficulty Swallowing / Hearing Loss / Infection / Earaches / Sores / Nosebleed
Respiratory:	Asthma / Bronchitis / Difficulty Breathing / Shortness of Breath / Vomiting Blood
Cardiovascular:	Hypertension / Murmurs / Chest Pain / Edema / Claudication / Ulceration /Phlebitis
Gastrointestinal:	Jaundice / Cirrhosis / Hepatitis / Abnormal Stool
Musculoskeletal:	Joint Pain or Swelling / Back Pain / Pain with Activity After Resting / Weakness /
Neurologic	Paralysis / Stroke / Tics / Tremors / Seizures / Numbness
Dermatology	Rash / Thickened Discolored Nails
Mental Status:	Alert and Oriented / Alert, Not Oriented / Confused / Lethargic

- -

FOR OFFICE USE

Temp: ___°, **Pulse** _____, **Respirations**____, **BP**___/___, **Height:** ___'___", **Weight:** ____**lbs, Shoe Size:** ______,

<u>**Medical Assistant**</u> ____________________ **reviewed this form and Confirmed information with patient.**

Information also evaluated by: ___________________________________ **D.P.M.**

Caring Foot and Ankle Specialists
David S. Wolf, D.P.M. & Gian D. Steinhauser, D.P.M. & Banafsheh Baharloo, D.P.M.
Foot & Ankle Specialists Accredited by American Board of Podiatric Surgery
11515 Chimney Rock Road • Houston, TX 77035 • (713) 728-3117 • (713) 728-2212
www.CaringFootAndAnkle.com

Financial Policy

Welcome to Caring Foot and Ankle Specialists. It is our goal to provide you with excellent care, not only medically, but in all other aspects as well. If you receive a bill from us that you do not understand or feel that you may have received in error, please call our office promptly at 713-728-3117.

Traditional Medicare Insurance:
Our office participates with Medicare. This means that if you have Medicare Insurance, we will send your claim to Medicare and we will adhere to Medicare's allowable fee schedule. Medicare sets an allowable fee for each service that they cover. Once you have met your annual deductible Medicare will pay us 80% of the allowable fee and you will be responsible for the remaining 20%. If you have a secondary insurance this amount will then be sent on to them and you will be billed for any remaining balance after their payment.

Medicare has strict guidelines concerning their coverage of routine foot care such as trimming nails, or paring corns and calluses. The doctor will be able to determine if your routine foot care is or is NOT covered by Medicare. Should you have a non-covered service such as this performed, you will be asked to pay for that service at the time of your appointment. We will also ask you to sign Medicare's Advance Beneficiary Notice (ABN) indicating you were informed that Medicare will not be paying for that particular service. We will give you a copy of the ABN for your records if you request it. **If you have any other service** such as a new patient office visit or a visit for a new problem **performed on the same day as routine nail care or another non covered service,** Medicare will be billed for the covered service **and** we will collect the uncovered service fee from you that day as well.

All Other Medicare Insurances Including Medicare Replacement Plans:
Caring Foot and Ankle Specialists accepts and participates with many commercial and **Medicaid** programs, but there are a few plans that we do not participate in. As a courtesy to our patients we will submit your claims to all other insurance companies **providing:**

- At each visit we receive a copy of all current insurance identification cards.
- Our Patient Information Form is current and correctly completed.
- Our Financial Policy is signed.

If we have not heard from your primary or secondary insurance within 60 days, you will be billed directly. In that event you must contact the insurance company directly to find out why your claim has not been paid.
It is the patient's responsibility to give us their current insurance information. **If** we do **not** have a copy of your **current insurance** card, or have received incorrect or old insurance information, all charges will become the **patient's responsibility.**

Referrals/Authorizations:
Referrals are the **patient's responsibility** to obtain, if your insurance requires one. We will do all we can to assist you, but it is ultimately your responsibility. If a required referral is **NOT** in place **PRIOR to your appointment,** we may **reschedule** the appointment until it is received or you may personally pay for the visit and all services provided at the time of service.

No Insurance:
If you do not have health insurance, charges for the day's medical service **are due at the time of service** unless other arrangements have been made with the billing department in advance. In many cases a **cash payment discount** may be given to patients without health insurance if they have a financial hardship.

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Financial Policy (Page 2)

All co-pays and co-insurances are due at the time of your appointment, as specified in your insurance contract and mandated by your carrier in our participating provider agreement.

- We ask that when you arrive for your appointment you are prepared to pay your co-pay as we are required to collect it by your insurance carrier. If you cannot pay your co-pay, then you cannot be seen.
- For your convenience Caring Foot and Ankle Specialists accepts cash, money orders, MasterCard, Visa, and personal checks, as well as Care Credit. **Payment is expected at each visit.** We reserve the right to reschedule your appointment if you are unprepared to pay your co-pay, co-insurance or unpaid balance.
- You will receive a billing statement for all personal balances due. If we have not received a response from you by phone or have not received a payment or letter regarding your **unpaid balance**, **after 60 days**, your account will be charged a **$20 reprocessing fee**. There is a $25 fee assessed for returned checks.
- We understand that temporary unexpected financial problems do arise. We encourage you to contact the office at immediately for assistance in managing your account. In cases of extenuating circumstances the doctors may be able to waive certain penalties or fees, if warranted, in a case-by-case basis.
- **If you have a substantial deductible** with your insurance policy, you may be **requested to pay a percentage of the day's charges at the time of service**. If you want to schedule surgery, your deductible, or a portion there-of may be due **before** the surgery is scheduled.
- **Referrals/Credit Card on File Policy**
  We may request to store your credit/debit card information electronically in our encrypted PCI & HIPPA compliant medical record system to provide convenient balance payments for the portion of services that your insurance doesn't cover, but for which you are liable. If you decline this authorization, an additional billing fee of $10 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Your credit card information is kept confidential and secure. Your payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has been paid and posted to the account.

  I authorize Caring Foot and Ankle Specialists to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

  □ Visa □ Mastercard □ Discover

  Credit Card Number _____ Expiration Date _____ / _____ / _____

  Cardholder Name _____

  Signature _____

  Billing Address _____City _____ State_____ Zip _____

Collections:

Caring Foot and Ankle Specialists will make every attempt to provide you with payment terms and options that meet your needs, if you have any financial troubles with paying your bill. However, if we do **not** hear from you by phone, mail or partial **payment within 45 days** of a statement being sent, you **may be referred to a collection agency**. In the event your account is assigned to collection, the patient agrees to be responsible for a 25% collection fee, as well as all court costs and attorney fees. However, please contact us before payment of your bill becomes an issue so that we can work out either a reasonable payment plan or other possible arrangement that best fits your financial situation. We dislike sending people to collections almost as much as they dislike being sent, so lets work together to resolve any financial before collections become a problem.

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Financial Policy (Page 3)

Disability/FMLA Forms:
It can take the doctors at Caring Foot and Ankle Specialists 15-20 minutes to complete a disability form, in addition to your normal medical office visit, as they must review your chart and fill in detailed information. Therefore there is a **$25.00 fee** for every disability form to be completed by the doctors. Usually these forms are completed after clinic hours and may take 3-4 business days to be completed depending on patient volume. The fee is payable **upon presentation** of the forms. The forms will **NOT** be completed until the $25.00 fee is received.

Missed Appointment Policy:
Caring Foot and Ankle Specialists reserves the right to charge a patient for a missed appointment. **If you cannot make your scheduled appointment**, **PLEASE CALL THE OFFICE** with at least **24 hours notice**. A charge for a missed appointment is NOT a charge for the service itself. One missed appointment, or severe weather problems will NOT result in a patient being charged. In the case of extenuating circumstances such as a family emergency or other mitigating event, where 24 hours notice was not given, we ask that you please call and explain the absence so we can excuse the absence appropriately. Consecutive missed appointments, or repeated missed appointments will be assessed a fee of **$25 for each missed appointment**. Habitually missed appointments could lead to a patient being discharged from the practice.

Also, considerable time and effort is expended in arranging and scheduling surgery for patients. The staff must coordinate with insurances, surgical facilities, and multiple physicians in a coordinated maze of paperwork and phone-calls that can take hours of our staff's time and effort, just to set up one surgery. So when a patient cancels a surgery at the last minute, it is a big deal. Not only do we lose considerable amount of time and effort already put in, we also lose the surgery time-slot that could have been used for another patient. In order to discourage last-minute cancelations we ask patients to give us at least **1 week notice prior to a surgery date to cancel or reschedule a surgery**, or the patient will be charged a **$75 Surgery Patient Cancelation/Rescheduling fee**, which will need to be paid prior to rescheduling the surgery. We understand that surgeries can be canceled for a variety of other reasons that are outside of a patient's control, such as insurance, health and surgical facility problems. In these unforeseen circumstances the patient would not be responsible for this fee.

Caring Foot and Ankle Specialists is dedicated to providing our patients with effective, kind and compassionate foot and ankle care, now and well into the future. Our financial policy has been developed to assist us in delivering that care in an efficient and economic way so that we can keep our doors open for all of our patients for many decades to come. We hope you appreciate that the only way we are able to provide you the quality healthcare you expect and deserve, is through the payments our patients, and insurance providers provide.

If you have any questions regarding this financial policy, please feel free to ask our staff.

We look forward to working with you on delivering the excellent care and medical services that we have been known for over 30 years.

I have read and agree to the terms of the Financial Policy given to me by Caring Foot and Ankle Specialists

PATIENT SIGNATURE: _____ **DATE:** _____/_____/_____

PRINT PATIENT NAME: _____

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ACKNOWLEDGMENT OF OPPORTUNITY TO REVIEW NOTICE OF PRIVACY PRACTICES

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of the Caring Foot and Ankle Specialists' Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in the Caring Foot and Ankle Specialists' Notice of Privacy Practices, please do not hesitate to contact a clinic representative for further detail.

Your signature also acknowledges that you are aware that a copy of the Caring Foot and Ankle Specialists' Privacy Practice is available online at: www.CaringFootAndAnkle.com, for you to review at any time.

_____

Patient Name (please print)

_____

Parent or Authorized Representative (if applicable)

AUTHORIZATION TO RELEASE INFORMATION

I authorize the following individuals to have access to my "Protected Health Information".

Please list names: _____

_____

I also give permission for Caring Foot and Ankle Specialists, to identify that they are calling from Caring Foot and Ankle Specialists, and to leave a brief message stating the nature of the phone call.

I also give permission to any medical provider from Caring Foot and Ankle Specialists to contact me and discuss my foot and ankle medical conditions with me, or authorized representative, via Text Message or Email, knowing full well that these methods of communication may NOT be fully secure and/or encrypted and therefore may NOT prevent accidental release of health information. If I initiate or respond to either methods of communication I also imply informed consent to communicate through these methods and do not hold the practice or provider liable for any data breaches incurred through these communications.

Signature: _____ **Date:** _____