Central Texas
FOOT SPECIALIST

Name: _____Date of Birth: _____

Weight: _____ Height: _____Shoe size: _____

Please list any specific problems you would like to discuss with the doctor: _____

_____

How long have you had this problem? Days_____, Weeks_____, Months_____, Years_____

Please rate your pain: 0 1 2 3 4 5 6 7 8 9 10 (severe)

Have you seen any other physicians for this problem: _____, When? _____

Please list any treatments you have received for this condition: _____

_____

Family Physician: _____Phone Number: _____Last visit date: _____

Past Medical History

(Please circle all that applies)

High blood pressure	Sickle Cell	Multiple Sclerosis	HIV/AIDS
Stroke / TIA	Thalassemia	Cerebral palsy	Syphilis
Angina/Heart attack	Diabetes Type I or II	Polio	Liver disease
Heart rhythm disorder	Eye disease	Seizure/Epilepsy	Hepatitis B or C
Heart valve problem	Kidney disease / Dialysis	Muscular dystrophy	Tuberculosis
Heart failure	Neuropathy	Panic disorder	Rheumatic fever
Asthma/COPD	Thyroid disorder	Anxiety disorder	Sleep apnea
Blood clot in vein	High cholesterol	Bipolar illness	Back trouble/Sciatica
Pulmonary embolism	Osteoarthritis	Depression	Skin disorder
Chronic bronchitis	Lupus/SLE	Psychiatric illness	Use of steroids in the past 6 months
Sarcoidosis	Rheumatoid arthritis	Dementia/ Alzheimer's	Stomach ulcers
Raynaud's	Psoriasis	Reflux/GERD	Gout
Anemia	Cancer Type: _____	Spinal cord injury Level: _____	Other Medical Problems:
Blood transfusion	Colitis	Ulcerative colitis	
Bleeding tendency	Lyme Disease	Crohn's Disease	

Allergies: (circle any that apply): NONE Penicillin Sulfa Aspirin Contrast Latex Iodine NSAIDS Shellfish Tape Codeine Food Allergies Metal Other: _____

Medications (please list all): **Local Pharmacy Name and Crossroads**: _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Hospitalizations (dates and reasons)**:** _____

Surgeries (please list all prior surgeries and dates**:** _____

_____

Family History (significant disease)**:** _____

Social History:

What is your current marital status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Other

Do you smoke or chew tobacco products? ☐ Yes ☐ No If yes, which one:_____
how much/how long? #cigs/packs _____day/_____year

Past smoking history: Year quit: _____Years used: _____

Do you consume alcoholic beverages? ☐ Yes ☐ No If yes, ☐ Rarely ☐ Less than 2 a day ☐ More than 2 a day

Past alcoholic history: Year quit: _____ Years used: _____

Please circle persistent issues you have had recently or frequently.

Generalized weakness	Nasal bleeding	Constipation	Numbness/ tingling/ burning of feet	Enlarged lymph nodes
Loss of appetite	Chest pain with exertion	Diarrhea	Poor balance	Immune disorder
Fever, chills	Pacemaker/defibrillator	Stomach ulcer	Dizziness	Osteomyelitis
Weight change	Cardiac arrest	Heartburn	Headaches/migraine	MRSA
Fatigue	Palpitations	Muscle Weakness	Depression	Varicose Veins
Night sweats	Heart murmur	Joint pain/ swelling	Claustrophobia	Swollen glands
Vision blurring	Lightheaded on standing	Leg swelling	Anxiety	Easy bruising
Dry eyes/ irritation	Wheezing	Pelvic pan	Sleep disturbances	Excessive bleeding
Hearing loss	Pain with coughing	Leg pain exertion or at night	Hallucinations	Rectal bleeding
Tinnitus (ringing in ears)	Shortness of breath	Dry skin/itching/rash	Suicidal thoughts	Pain/bleeding/ difficulty with urination
Sinus problems	Difficulty breathing when laying down	Thick scar/ keloid	Eating disorder	Sexually transmitted disease
Congestion	Pain With Breathing	Acne	Kidney Stones	Previous Foot/Leg Wound
Difficulty swallowing	Abdominal pain	Eczema	Hair loss/ hair growth	Previous pressure ulcer
Sore throat	Nausea/ vomiting	Hives/ urticarial	Heat/cold intolerance	Language, cultural, or religious concerns

To the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and the staff of any changes to my medical status.

_____

Printed name of patient *Signature of patient/parent or guardian* *Date*

Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

PLEASE READ AND INITIAL:

_____ **Insurance:** Your insurance coverage is a contract between you and your insurance company. We are not a third party to this contract. We will bill your insurance company primary and secondary (if you applicable), as a courtesy. Your insurance company does not guarantee payment for services rendered. Your insurance company makes the final determination of your benefits and eligibility at the time the claim is reviewed. By signing the line below, you hereby agree that you understand you are solely responsible to pay any portion of charges not covered by your insurance company.

_____ **Verification of Benefits:** You as the policy holder are primarily responsible to know your insurance benefits. We may assist you, if time permits, to verify your podiatric coverage available under your policy. Insurance DOES NOT guarantee payment of benefits quoted and subsequently you will be responsible for any coinsurance or deductibles for services not covered by your insurance company. We must have a copy of your valid insurance card and photo ID in order to process your claims. If your insurance information changes, we must be notified. Failure to cooperate will mean that you will be responsible for the charges incurred.

_____ **Required Payments:** You will be responsible to pay any co-payment, deductible, coinsurance, or fees not covered by your insurance company at the time services are rendered. We do not accept letters of protection. Any outstanding balance greater than 60 days must be paid prior to being seen by the physician or you will be required to reschedule your appointment. You may pay with cash, check or a credit card.

_____ **Monthly Statements: You will receive a statement via TEXT, if you DO NOT want to receive a text you have the option to get it emailed. Please let the front desk know.** You will receive a statement only if you have an outstanding balance on your account. We request that if you receive a statement, that you make a payment within 30 days of receipt. If your balance becomes delinquent past 60 days, your account will be referred to a collection's agency and you will be charged a 25% fee.

I have read, understand, and agree to the above Financial Policy. I understand charges not covered by my insurance company, as well as applicable co-payments, deductibles, and coinsurance are my responsibility and are due at the time of service.
I authorize my insurance benefits to be paid directly to Central Texas Foot Specialist, P.A.

I authorize Central Texas Foot Specialist, P.A. to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Patient/Parent or Guardian Signature: _____ Date: _____

If there is anyone that you authorize Central Texas Foot Specialist to release your personal health and account information, please list their names below. I give permission for Central Texas Foot Specialist, P.A. to share my protected health information with:

_____ _____
Printed Name Relationship to Patient

_____ _____
Printed Name Relationship to Patient

I wish to be contacted in the following manner:

- ☐ Home Phone
- ☐ Cell Phone
- ☐ Work Phone
- ☐ Email: _____

Ok to leave a message with detailed information:

- ☐ Home Phone
- ☐ Cell Phone
- ☐ Work Phone

Office Policies and Procedures

We would like to take this opportunity to thank you for choosing our office to treat your podiatric needs and concerns. Below is a list of our office policies. After reviewing the policies below, **please initial** next to each policy indicating that you have read, understand, and will adhere to the written policies.

_____ **Patient Treatment:** It is our primary goal to restore and maintain the health of your feet. We strive to provide you with the highest quality of podiatric care. If you have any questions regarding your treatment, please feel free to consult with your physician who is providing your care. It is our responsibility to deliver the best health care possible. Your initials and signature will act as an authorization for treatment.

_____ **Appointments:** If you are unable to keep your appointment, we require that you contact our office within 24 hours. A missed appointment with no prior notice will result in a $50 missed appointment fee. Patients with 3 or more missed appointments without proper notification will be asked to transfer their records to another physician. Also, as a courtesy to the physician and other patients, we require that you be on time for your appointment. If you are more than 15 minutes late you will be required to reschedule your appointment.

_____ **Release of Records:** If you want your records release to another physician or facility you must sign a Release of Records form indicating who we are releasing records to, as well as which relevant information you would like us to release. Copies of medical records are available upon request for a fee of $25. Please allow 7-10 business days to have your records available.

_____ **Referrals:** If your insurance company requires a referral, it is your responsibility to obtain it. If you present to the office without your referral, you will be required to reschedule your appointment, or you may opt to pay out of pocket for services rendered. Referrals must be generated from your primary care physician or referring doctor.

_____ **Outpatient Surgery:** If you schedule outpatient surgery there is a $50 fee should you reschedule that surgery to a different facility or date. There is also a $200 cancellation fee if surgery is cancelled for any reason within 14 days of the procedure. There are no exceptions.

Acknowledgement of Receipt of Privacy Notice

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand Central Texas Foot Specialist, P.A. reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment. The duration of the authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information form persons not listed will require a specific authorization prior to disclosure of any medical information. By signing below, I acknowledge that I have read and understand the above listed Office Policies and Procedures and that I have been provided with the Notice of Privacy Practices.

Signature: _____ Printed Name: _____ Date: _____

How Did you hear about us?

- ☐ Who may we thank for referring you? _____
- ☐ Central Texas Foot Specialist Sign
- ☐ Insurance Website: _____
- ☐ Advertisement (which one): _____
- ☐ Other: _____

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