WELCOME TO OUR PODIATRY PRACTICE!

TEXOMA FOOT & ANKLE SPECIALISTS
101 N. US Hwy 75 Denison TX 75020
903-463-1000 phone
833-974-2040 fax

ANNA FOOT & ANKLE SPECIALISTS
604 W. White St. Anna, TX 75409
972-905-3919 phone
833-303-0126 fax

______________ ________________________________ ________________________ __________
TODAY'S DATE LAST NAME FIRST NAME MIDDLE INITIAL

______________________ __________ ________________________________ ☐ MALE
DATE OF BIRTH AGE SOCIAL SECURITY # ☐ FEMALE

____ __________________ ______ __________
MAILING ADDRESS CITY STATE ZIP CODE

________________________ __________________________ __________________________
HOME PHONE CELL PHONE WORK PHONE

____
EMAIL ADDRESS

________________________________ ____
EMPLOYER JOB DESCRIPTION

____________________________ ____________ ________________________________
SPOUSE'S NAME DATE OF BIRTH SPOUSE'S EMPLOYER

IF PATIENT IS A MINOR/CHILD COMPLETE THE FOLLOWING:

FATHER'S & MOTHER'S OR GUARDIAN'S NAME(S): ____

PARENT'S EMPLOYER: ________________________________ WORK PHONE: __________________

PARENT'S EMPLOYER: ________________________________ WORK PHONE: __________________

INSURANCE SUBSCRIBER NAME: __________________________ SUBSCRIBER BIRTHDATE: __________

INSURANCE SUBSCRIBER HOME ADDRESS IF DIFFERENT FROM PATIENT'S ABOVE:

____

EMERGENCY CONTACT: ____

RELATIONSHIP TO YOU: ______________________ CONTACT PHONE: __________________________

ARE YOU IN HOSPICE CARE? ☐ Yes ☐ No If yes, facility: ______________________________

ARE YOU IN SKILLED NURSING? ☐ Yes ☐ No If yes, facility: ___________________________

Designated case manager/nurse: ____________________________ Phone: __________________

TRANSPORTATION NAME & PHONE NUMBER: ☐ Self ☐ Other: ______________________________

HOW DID YOU HEAR ABOUT US?

- ☐ Saw the sign/ building
- ☐ Newspaper/other advertisement; which ad? ________________________________
- ☐ Internet/ website; which site? ____
- ☐ Referred by another patient; which patient? ______________________________
- ☐ Referred by my doctor; which doctor? ____________________________________
- ☐ Other: ____

I certify that all information given above and in my following medical history is correct to my knowledge.

PATIENT SIGNATURE / SIGNATURE OF GUARDIAN: ____

If guardian, print name and relationship: ____

Name: ______________________________________

Date of Birth: ____________________________

SYMPTOMS

What is the chief complaint today?

____

____

____

Which side: ☐ Right ☐Left

On a Scale of 1 (mild) – 10 (in tears), rate pain:
Highest ______ & Lowest ______ in last 24 hrs

Describe Pain: ____________________________

Area of Pain: ______________________________

How long have you been having symptoms?

____

What makes it hurt the most? ______________

____

What have you tried to help the pain?

☐ Change shoes ☐ Decrease activity
☐ Advil/ Ibuprofen ☐ Tylenol/ Acetamin.
☐ Stretching at home ☐ Steroid Injection
☐ Physical Therapy ☐ Other: ______________

____

FAMILY DOCTOR: ________________________

DOCTOR CITY/STREET: _____________________

PHARMACY NAME: _______________________

PHARMACY CITY/STREET: ___________________

LOWER EXTREMITY DETAILS

Height_______ Weight_______ Shoe Size: ____

Previous foot, ankle, or leg problems:

____

____

Previous podiatrist: _______________________

Who else have you seen for this problem?

____

Allergies & Drug Intolerances

☐ NO KNOWN DRUG ALLERGIES

☐ Adhesive/Tape ☐ Aspirin ☐ Codeine
☐ Anesthetics ☐ Iodine ☐ Penicillin
☐ Food Allergies ☐ Sulfa products
☐ Other: _________________________________

____

____

VACCINATION HISTORY

Have you received the Flu vaccine since the previous August?

☐ Yes – MM/ YYYY _________________ ☐ No

FAMILY HISTORY

FATHER: ☐ Living, Year born ________ ☐ Deceased

Medical conditions/ cause of death: _________________________

____

MOTHER: ☐ Living, Year born ________ ☐ Deceased

Medical conditions/ cause of death: _________________________

____

Medical conditions of siblings (specify brother/sister): _________

____

____

____

SOCIAL HISTORY

Do you have difficulty walking/climbing stairs? ☐ Yes ☐ No

Do you normally use: ☐ Walker ☐ Cane ☐ Daily-use brace
☐ Wheelchair ☐ No aids ☐ Other: __________________

Occupation: ____

What is your cigarette-use status?

☐ Never ☐ Former smoker, but not currently
☐ Every day smoker ☐ Some-day smoker

How many years have you smoked? _________________________

Age you started smoking? ___________________________________

If you previously smoked, when did you quit? ________________

# of packs of cigarettes per day you currently smoke? __________

Do you use smokeless tobacco?

☐ Never ☐ Former user, but not currently
☐ Current chew user ☐ Current snuff user
☐ Current moist powdered tobacco user

Do you vape/ use an e-cigarette?

☐ Never ☐ Former user ☐ current user

Avg # of alcoholic drinks per week? ☐ 0 ☐ 1-5 ☐ 6-10 ☐ 10+

Recreational Drugs? ☐ Yes ☐ No

What drugs? ____

What is your level of caffeine consumption?

☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Do you have an Advanced Directive? ☐ Yes ☐ No

Do you have a medical power of attorney? ☐ Yes ☐ No

If yes, who is your POA? _______________________________

Exercise level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Marital Status: ____

NAME: ____ DATE OF BIRTH: ____________________

PAST MEDICAL HISTORY

Check to indicate that you have any of the following currently or in the past:

- ☐ ADD/ ADHD
- ☐ Above Knee Amputation
- ☐ Accidents/ Injuries
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety
- ☐ Artificial joint _______________
- ☐ Asthma
- ☐ Athlete's Foot
- ☐ Atrial Fibrillation
- ☐ Atrial Septal Defect
- ☐ Autism / Asperger's
- ☐ Bell's Palsy
- ☐ Below Knee amputation
- ☐ Bipolar
- ☐ Bleeding disorder/ Hemophilia
- ☐ Blood Clots/ Phlebitis
- ☐ Blood Transfusion
- ☐ Brain injury
- ☐ CHF: Chronic Heart Failure
- ☐ COPD
- ☐ Cancer, Type:________________
- ☐ Cerebral Palsy
- ☐ Chicken Pox (Varicella)
- ☐ Coronary Artery Disease (CAD)
- ☐ Crohn's Disease
- ☐ Currently Pregnant, month ______
- ☐ Deep Vein Thrombosis
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes **Type #:** _____
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Ear/ Nose/ Throat issues
- ☐ Eczema
- ☐ Endocrine disorder
- ☐ Epilepsy
- ☐ Fibroid Tumors
- ☐ Fibromyalgia
- ☐ Foot deformity
- ☐ Frost bite
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ HIV positive ☐ AIDS
- ☐ Hard of hearing
- ☐ Heart attack (Myocardial infarction)
- ☐ Heart Murmur
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Immune Disease, Specify: ____________________________
- ☐ Intellectual Disability
- ☐ Kidney Disease
- ☐ Leg/ Foot ulcers previously
- ☐ Liver disease
- ☐ Lung disease
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Lymphedema
- ☐ Macular Degeneration
- ☐ Multiple Sclerosis
- ☐ Myasthenia Gravis
- ☐ Nails: ☐ Fungus ☐ Deformity
- ☐ Neuropathy
- ☐ Organ Transplant: _____________
- ☐ Osteoarthritis (bone/ not RA)
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pain management care
  Physician: ___________________
- ☐ Parkinsonism
- ☐ Pelvic Pain
- ☐ Peripheral Arterial Disease (PAD)
- ☐ Peripheral Vascular Disease (PVD)
- ☐ Polio
- ☐ Psoriasis
- ☐ Raynaud's Disease/phenomenon
- ☐ Restless Leg Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Shingles (Herpes Zoster)
- ☐ Sickle Cell Anemia
- ☐ Spinal Cord Injury
- ☐ Stroke
- ☐ Substance Abuse
- ☐ TIA
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Varicose Veins
- ☐ Venous Insufficiency
- ☐ Abdominal veins
- ☐ Bulging veins
- ☐ Diagnosed with arterial disease
- ☐ Diagnosed with vein disease
- ☐ Prolonged Sitting
- ☐ Prolonged Standing
- ☐ Purple Spots on feet
- ☐ Red/purple spider veins
- ☐ Skin discoloration below knee

SURGICAL HISTORY

- ☐ Artificial heart valve

Other surgeries, injuries, illnesses:

____
____
____
____
____
____
____
____
____
____

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PATIENT MEDICATION LIST

TODAY'S DATE: ______________________________

PATIENT NAME: ____ DATE OF BIRTH: ________________________

Medication Name	Dosage amt	How often you take it

Continue on back as necessary.

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HIPAA CONSENT: WHO CAN ACCESS MY INFORMATION?

I, (Patient Name)____, authorize the following person(s) to access my medical records or speak to a staff member of the above named practice regarding my patient care, appointments, and account. This will be in effect from the date signed on this authorization forward until I revoke these privileges through written notice.

I understand that this is an authorization to allow the parties below to discuss my appointments, treatment of care, lab results, test results, accounting ledger, and any other information obtained at the practice locations above or any satellite offices operated by said practices. I also understand that individuals not listed below will be denied access to the above mentioned information. Medical personnel are automatically enabled to receive relevant information under HIPAA laws; it is not necessary to list your doctors or insurance company here.

____ Authorized Party's Name	_________________________ Relationship to Patient
____ Authorized Party's Name	_________________________ Relationship to Patient
____ Authorized Party's Name	_________________________ Relationship to Patient
____ Authorized Party's Name	_________________________ Relationship to Patient

Any limitations to the access of your records must be listed below:

____

____

____ Patient Signature	_________________________ Date Signed

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PATIENT CONSENT FORM

I understand that as a part of the provision of healthcare services, my physicians at Texoma Foot and Ankle Specialists create and maintain health records and other information describing, among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Policy that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change the privacy notice and practices and that I will be given a new copy of the privacy policy notice with any significant changes prior to continuing service with Texoma Foot and Ankle specialists.

By signing this form, (**PLEASE INITIAL EACH LINE**):

_____ HIPAA: I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and healthcare operations. I do so with the understanding that my health records can include but are not limited to written, oral, and electronic records, and this privacy policy notice applies to all records of any format. I authorize all of my other physicians to release my medical records to my podiatrist at Texoma Foot and Ankle Specialists for the purpose of medical treatment and to assist in billing for the services rendered by my podiatrist.

_____ PRIVACY POLICY: I attest that I understand my rights associated with the Health Information Portability and Accountability Act as explained in the privacy notice. I have been given the opportunity to restrict access to my records and have completed the HIPAA form allowing me to do so.

_____ INSURANCE: I agree to allow employees of this office to act on my behalf in attempting to collect payments on insurance claims filed for services rendered to me, including contacting insurance companies, providing necessary information and records, and issuing complaints to the State Insurance Commissioner as needed to ensure timely payment from my insurance carrier.

_____ FINANCES: I understand that I am ultimately responsible for my bill. Although Texoma Foot and Ankle Specialists will attempt to collect payment from my insurance company, I understand that I am responsible for all over-the-counter purchases and all cost-share portions (copay, deductible, coinsurance, non-covered charges, etc) as deemed my responsibility by my insurance company.

_____ EMAIL: I understand that this office will respond to requests for documents sent via email if requested; I understand that this is not considered a secure method of communication and that I am responsible for all requests for emailed documentation.

_____ PHARMACY: I authorize this office to collect data regarding my prescription medications from electronic pharmacy databases.

_____ PHONE: I consent to contact by telephone, including automated messages regarding appointments, balances, etc.

_____ TEXT MESSAGES: I consent to receive text messages from this office and understand that I am responsible for any applicable text messaging fees as determined by my cellular phone company.

I attest that this consent is valid until such time that I revoke it in writing. I understand that revoking this consent will not be applicable to instances where information has already been released. I recognize that a copy of this authorization, including digital, may be used in place of the original.

SIGNATURE OF PATIENT/ LEGAL GUARDIAN	TODAY'S DATE
PATIENT NAME (printed)	DATE OF BIRTH
LEGAL GUARDIAN'S NAME (if applicable)	RELATIONSHIP TO PATIENT

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FINANCIAL POLICIES

1. Our offices will attempt to verify your benefits before you are seen in office. If you would like an explanation of how your insurance will process your visit, we would be happy to provide this information prior to your appointment. You will be quoted an estimate based on the best information we are able to obtain from your insurance company. This is, however, **ONLY AN ESTIMATE**. No amount quoted in-office or over the phone is final, even in the case of surgeries. Final pricing is based upon your contract with your insurance company and their contract with us, and it will be determined only after all insurances process your claims.

2. **PAYMENT IS EXPECTED AT THE TIME OF SERVICE**. Our offices collect known copays and deductibles for office visit evaluation services at check-in; additional services performed, such as x-rays, injections, nail surgeries, nail trimming fees, wart removal, walking boots or other equipment, etc. may result in additional fees being collected at check-out. Amounts collected are estimates only.

3. **RETURNED CHECKS** will be subject to a fee of $25.00. When a check is returned, we will contact you via mail. Thirty days after the date on the letter, your account may be turned over to the county to pursue payment of the invalid check and fee. After a check has been returned, you may be asked to make future payments by cash, money order, or credit/debit card.

4. If an item is only available over-the-counter or out-of-pocket, we will endeavor to give you **ADVANCE NOTICE OF NON-COVERAGE**. Individual insurance plans may have exclusions of which we are unaware, however. If you would like an estimate for services or equipment or if you would like us to verify coverage for a specific service with your insurance, please speak to a staff member at any time. Please be aware that we can only relay the information given to us; no decisions of insurance are final until claims have processed.

5. If your claim is denied, we will **ATTEMPT TO APPEAL** the claim whenever possible. If after all of our attempts are exhausted, your insurance still determines that the claim is your responsibility, we must honor that decision. We will assist you in any further attempts at appeal which you wish to execute as the patient / insurance client, including providing necessary information and or clinical notes.

6. If you are delinquent in making payment, we will send you at least **THREE STATEMENTS**. After we have sent out three statements with NO PAYMENT or with NO CHANGE in balance, your account may be sent to **COLLECTIONS**. To avoid collections, please try to make a payment as soon as you receive a statement. We DO allow installment payments on balances.

7. While some fees do need to paid upfront, in many cases, we are able to setup **PAYMENT PLANS,** if necessary. Please speak to our check-out associate for assistance in starting a payment plan. Should you default on your payment plan, your account may be turned over to collections for failure to make payment. If you are at any point unable to meet your arranged payment amount, please contact our office and communicate with us so that we can try to assist you and prevent any collections actions; a new payment arrangement can be negotiated as your situation changes.

8. If we receive **RETURNED MAIL** on an outgoing statement, we will attempt to contact you by phone to obtain a valid address. If your phone number is no longer valid or you refuse to offer a correct address, your account may be immediately turned over to collections.

9. If your account must be **TURNED OVER TO A COLLECTIONS COMPANY**, the following conditions apply:
   a. Collections companies will pursue payment to the fullest extent possible, including possibly reporting to the credit bureaus or involvement of attorneys through the legal process for debt collection.
   b. You must contact the collections company to make any payment arrangements until the account is paid in full.
   c. If you wish to pay the balance in full, you may do so in our office or with the collections company.
   d. While your account is in collections, you cannot receive additional care in the office; if you receive care at a facility where our physicians are on staff, they may offer treatment in the hospital setting.
   e. Records requests will be answered, but records fees will be due upfront as per normal procedure.

10. Currently our office does NOT charge late fees.

11. **CANCELLED SURGERIES** with less than one week notice will be subject to **a $150.00 cancellation fee** representative of the amount of time and effort our staff, the hospital staff, anesthesiologists, and equipment providers undergo to schedule each surgery. You are legally responsible for these fees and your account may be turned over to collections for payment of these fees.

12. At all times, **COMMUNICATION** and a **DEMONSTRATED ATTEMPT TO MEET YOUR FINANCIAL OBLIGATIONS** will be taken into consideration before any Collections actions are taken. This means that if it is possible for you to pay anything towards a debt, even if the amount is small, that would assist us in delaying any additional action that could be detrimental to you. We recognize that individuals face different challenges, and we are prepared to try to work with you and your budget in payment of your medical fees. Our biller can be reached to set up payment plans or answer questions at 903-463-1000 extension 207#.

By signing below, I acknowledge that I have read the above financial policies and understand that if I choose to receive service, then I am bound by these policies.

____ _________________________

PATIENT NAME (PRINTED) DATE OF BIRTH

____ _________________________

PATIENT OR GUARDIAN SIGNATURE TODAY'S DATE